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LONG-TERM NEEDS OF THE ELDERLY: A FEDERAL-STATE-PRIVATE PARTNERSHIP

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-EIGHTH CONGRESS

SECOND SESSION

SEATTLE, WA

JULY 10, 1984

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CONTENTS

Page

Opening statement by Senator Daniel J. Evans, presiding 1

CHRONOLOGICAL LIST OF WITNESSES

Ferguson, Bruce, Olympia, WA, assistant secretary, community services, department of social and health services, State of Washington 4
Katterhagen, Anne Kirchner, Tacoma, WA, executive director, Hospice of Tacoma 14
Wintringham, Karen, assistant to the senior vice president and chief financial officer, Group Health Cooperative of Puget Sound, Seattle WA 17
Wagster, Daniel O., Portland, OR, senior vice president and regional manager, Kaiser Fondation Health Plan of Oregon 25
Haugan, John F., administrator, Lilac Plaza, Spokane, WA 32
Birnbaum, Hilde M., Ph.D., Seattle, WA, vice chair, Senior Caucus of Group Health Cooperative of Puget Sound 47
Jensen, Laurie, Seattle, WA, chair, Washington State Legislative Committee, American Association of Retired Persons 51
Ambur, Dr. Richard F., Seattle, WA, president, Washington State Medical Association 63
Twersky, Reva K., Seattle, WA, member, Seattle-King County Advisory Council on Aging 74
Veblen, Marthanna E., retirement counselor, Seattle, WA 75
Girke, LaVerne, Seattle, WA 79
Wiseman, Thelma, Seattle, WA 80

APPENDIXES

Appendix 1. Material submitted by witnesses:
- Item 1. Letter and enclosure from Daniel O. Wagster, senior vice president and regional manager, Kaiser-Permanente Health Care Program, Portland, OR, to Senator Daniel J. Evans, dated August 13, 1984 83
- Item 2. Magazine article, "Kaiser-Permanente's Medicare Plus Project: A Successful Medicare Prospective Payment Demonstration," submitted by Daniel O. Wagster 91
- Item 3. Magazine article, "Survey Finds Elderly 'Highly Satisfied' With Kaiser Portland's Medicare Plus Program," submitted by Daniel O. Wagster 104
- Item 4. Magazine article, "Fallon's Senior Plan: A Summary of the Three Year Marketing Experience," submitted by Daniel O. Wagster 106
- Item 5. Magazine article, "Elder Care for the 1980's: Health and Social Service in One Prepaid Health Maintenance System," submitted by Daniel O. Wagster 110
- Item 6. "Guidelines for Persons or Groups Interested in Building a 'Full-Program' Retirement Residence in Their Community," submitted by John F. Haugan 117
- Item 7. Letter from Reva K. Twersky, Seattle, WA, to Senator Daniel J. Evans, dated July 19, 1984 128

Appendix 2. Letters and statements from individuals and organizations:
- Item 1. Letter and enclosure from Edgar F. Borgatta, Ph.D., director, Pacific Northwest Long-Term Care Center, University of Washington, Seattle, WA, to Senator Daniel J. Evans, dated August 14, 1984 129

Page

Appendix 2. Letters and statements from individuals and organizations—Continued

Item 2. Letter and enclosure from Frank Baker, vice president, Washington State Hospital Association, Seattle, WA, to Senator Daniel J. Evans, dated July 18, 1984 ---- 131

Item 3. Statement of Sue Loper-Powers, Seattle, WA, president, Washington State Nurses Association ---- 133

Item 4. Letter from Elaine G. McIntosh, Seattle, WA, president, board of directors, Washington State Hospice Organization, to Senator Daniel J. Evans, dated June 22, 1984 ---- 134

Item 5. Statement of Richard F. Gorman, Seattle, WA ---- 136

Item 6. Excerpt from Letter from Carl R. Johnson, executive director, Columbia Club of Seattle, WA, to Senator Daniel J. Evans, dated July 20, 1984 ---- 137

Item 7. Statement of Dorothy C. Fleming, Seattle, WA ---- 138

LONG-TERM NEEDS OF THE ELDERLY: A FEDERAL-STATE-PRIVATE PARTNERSHIP

TUESDAY, JULY 10, 1984

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Seattle, WA.

The committee met, pursuant to notice, at 9:30 a.m., in the South Auditorium, Federal Office Building, Seattle, WA, Hon. Daniel J. Evans presiding.

Present: Senator Evans.

Also present: Lisa Marchese, legislative assistant to Senator Evans.

OPENING STATEMENT BY SENATOR DANIEL J. EVANS, PRESIDING

Senator EVANS. The hearing will please come to order.

Good morning to all of you, and welcome to this official hearing of the Senate Special Committee on Aging. If there is one thing we all share in common as people, it is just that: aging. Inexorably with each passing day, we are all aging. How we age, under what circumstances, and how well, only the future will tell. But there are many things we can do as individuals cooperatively and through government to help ease that passage.

Today, we are here to examine the existing partnership between the Federal and State governments as well as the private sector for the provision of long-term care to the Nation's elderly, an issue which has become one of the most pressing public policy questions facing the Nation in the coming decade.

The importance of developing an effective and comprehensive long-term care policy nationally cannot be overstated. The future demand for long-term care services throughout the Nation will be much greater than it is today.

In the Bureau of Census latest projections, 21.7 percent of the population will be over age 65 by the year 2050, a substantial increase, virtually a doubling of the current 11.4 percent.

I might say in passing that two facts seem to jump out from those statistics. First, I suspect with increasing health and activity and ability, fewer and fewer people will want to retire at age 65, but will be effectively working and involved in the community for many, many years beyond that. Although the increase is dramatic by the year 2050, we do have something of a breathing spell for the next decade or more. The people reaching age 65 during the next decade will be those who were born in the 1920's. And the number of people born during those years gradually declined until the mid-1930's. And it was only toward the latter part of the 1930's that the birth rates began to

climb, the number of children born began to soar, and of course we are all familiar with the war-baby boom of the immediate post-World War II era.

So, by the turn of the century we are going to see the beginnings of that acceleration in the numbers reaching retirement age. And of course it will be in full swing and in fact will have reached its peak by the year 2050. That breathing spell is really nothing more than time for us to plan, for us to try to prepare for what we know statistically and demographically is coming. And how we deal with it depends pretty much on our willingness to look ahead and to plan.

Of particular importance with respect to that long-term care is the percentage of our total population who are 85 years and older. Today, it is 1 percent. By the year 2050, it will be over 5 percent, a fivefold increase in the number of people over age 85.

In light of the strong correlation between age, degree of disability, and utilization of long-term care, this greying of our population signifies a substantial increase in the demand for services. Washington State today has the fastest growing elderly population in the country. And many of you may have seen those statistics in the paper just a few weeks ago. I am not quite sure why, but we are apparently an attractive place for people to move or to stay, or perhaps we are just healthier than most. Senior citizens 65 and over account for nearly 14 percent of this State's population. In the Seattle-King County area alone, older Americans represent over 15 percent of the population.

In general, long-term care has become a common phrase which refers to a full spectrum of services needed by older Americans to help them cope with chronic illness and physical disability. Services which may be needed depend on the degree of disability and range from hospital and nursing home care to intermittent community services such as nursing, home health aides, homemaker visits in the home, home-delivered and congregate meals, transportation, and many other social supports.

Although long-term care services are available through such public agencies as hospitals, senior centers, nursing homes, and home health agencies, the bulk of long-term care is provided by the family and friends of those who are in need of assistance. In fact, one significant statistic was brought to the attention of the Special Committee on Aging in a recent public hearing. Nationwide, approximately 70 to 80 percent of all support provided for the elderly is given by family and friends. That means in essence that government is providing 20 to 30 percent of the needed support to care for older Americans.

I believe this statistic has a few rather general implications for future reforms in Federal health and long-term planning. And perhaps we will elicit some additional ideas from the hearing this morning. Most senior citizens, having the choice, prefer living and being cared for in the home, as opposed to traditional institutional settings. Yet medicare and medicaid are inherently biased toward an institutional care delivery system.

It has also been the practice to institutionalize disabled and impaired elderly in those parts of the country where nonmedical, community-based support services do not exist. Not only does this phenomenon place an additional financial drain on medicaid costs for nursing home services, but it has the effect of institutionalizing individuals

who, with access to certain nonmedical services, would be capable of living independently.

The cost of nursing home services for the elderly is the single fastest growing component of total national health expenditures. In 1982, nursing home care cost the Federal Government nearly $27 billion. Total institutional long-term care expenditures under medicaid reached $13 billion in 1982, representing an annual growth rate of 16 percent since 1977. If Federal policy is to move beyond the traditional medical model, institutional approach to a more open and community-based system, emphasizing the independence of the individual, then Federal policy must provide States, localities, and the private sector with sufficient incentives to do so. This, in turn, raises another area of concern for the development of future health and long-term care policy. We need to formulate a consensus and consolidate a more effective partnership between both the public and private sectors to meet the long-term care of older Americans.

Currently, there is no agreement on what the appropriate roles and responsibilities should be for the Federal, State, and local levels of government, as well as the private sector. Each has a different idea of who is responsible for what.

Formulating a strong intergovernmental relationship must start with an extensive review of existing Federal policy. Since I have been a member of this Special Committee on Aging, I have participated in various oversight and investigatory deliberations on major medical programs for older Americans. The Federal policy which shapes these programs often emanates from two ill-conceived premises.

First, we tend to regard the elderdly as a homogeneous group. We assume that they have the same needs and desires, failing to recognize the diversity within this segment of our population.

Second, we always assume the inevitability of old age. We expect everyone over 60 to become a burden on society. I must say in passing that President Reagan would not agree with that, and many others would not as well. We fail to recognize the valuable contributions older Americans can make to the rest of society. Although at the Federal level we are exploring various long-term care policy alternatives, we must build future reforms on a solid foundation, one which recognizes these apparent flaws in Federal policy planning.

In the Northwest, we have some significant examples of the main initiatives under consideration at the Federal level which we hope to examine closely during today's hearing.

We will begin with a review of Washington State's policy initiatives in the area of long-term care. The Omnibus Reconciliation Act of 1981 granted States broad flexibility in developing alternative long-term care delivery systems under medicaid. In January 1983, the Washington State Department of Social and Health Services was granted a home and community-based medicaid waiver from the Department of Health and Human Services. The State has developed and begun implementation of the Community Options Program-Entry System. COPES offers services ranging from congregate care, adult family home care, and personal care.

Our second panel is composed of health-care professionals who will discuss the existing as well as alternative delivery systems for long-term care. And our third and final panel will present testimony from a consumer-oriented perspective.

In addition to the scheduled witnesses, we hope to have enough time at the end to take short additional testimony on the subject from members of the audience. If there is not enough time for everyone to be heard, the committee will take written comments, and they will be part of the record and be very important additions to us as we deal with this important issue.

There are special forms, incidentally, in the back of the room that may be used by those that would like to submit written comments. If you do not have a chance to make a statement during the course of the hearing, you may mail your comments to my office or hand them in today.

Welcome, and I am delighted to see so many here today. It is obvious that your interest coincides with the importance of this issue.

I would like to introduce first Lisa Marchese of my staff who is in charge of our human services and a wide variety of elements. She is a busy staff person, very able, and will work with anyone here who would like to submit additional testimony and work with you and with me on developing initiatives and programs that may be of value to us.

Let us start now with testimony. We welcome Bruce Ferguson, assistant secretary of the Washington Department of Social and Health Services.

Bruce, proceed.

STATEMENT OF BRUCE FERGUSON, OLYMPIA, WA, ASSISTANT SECRETARY, COMMUNITY SERVICES, DEPARTMENT OF SOCIAL AND HEALTH SERVICES, STATE OF WASHINGTON

Mr. FERGUSON. Washington State, like most other States, does not have a long-term care program per se. Rather, what we have is an array of services that have grown up under individual programs which combined provide for the long-term care of the elderly and disabled. These services include those that are provided directly by departmental caseworkers as well as those that are purchased through departmental programs from private and public providers, as well as a vast array of services that are provided and purchased under the auspices of the area agencies on aging. And we hope of course that all of these together complement the care that is provided by family and friends, which, as Senator Evans mentioned, is the preponderance of care that is provided to persons in need of long-term care.

Within Washington State, although we are a relatively healthy population, there is still about 15 percent of the older population that needs some form of assistance in personal care and mobility. And this group, age 75 and older, represent the fastest growing segment of our population.

In addition, the advances in medical technology have provided some dramatic increases in the number of disabled people that are requiring long-term care services. So, with the increase in the disabled population as well as the rapid increase in the over-75 population, the demand for long-term care services is escalating at a fairly rapid pace. We feel strongly that this provides government at all levels with a tremendous challenge in terms of planning for the delivery of services to these populations. It is an opportunity, I think, in that we have an opportunity to plan rather than to react. So often we are in a position of

simply reacting to problems that are in hand. I think in this case we have an opportunity to plan sensibly for the delivery of services to this rapidly growing segment of our population.

In recognition of this opportunity, several years ago the department established a long-term care planning group to bring together those programs within our department that comprise the long-term care program. Our objective was to coordinate the planning for, and the delivery of services to the elderly and disabled population.

The first task of this group was to articulate a policy framework for the department so that we, in fact, could have a basis for our budget and program planning efforts. I would like briefly to review the five major elements of our long-term care policy.

The first—and this is a point that Senator Evans made in his opening comments—and that is that we feel it is very important that our programs sustain and increase the informal care that is given by family and friends to the elderly and disabled population. It is very clear that this comprises the vast majority of care that is delivered, and I think it is incumbent upon governmental programs to foster an increase in that care rather than to provide a substitute for that type of care.

The second element of our policy is that people that are served in the long-term care system should maintain the maximum amount of independence possible within reason. With medical technology what it is today, it is of course possible to maintain virtually anyone in their own home. However, the cost can become very prohibitive. But within reason we feel it is important that people that are served within the system should maintain the maximum amount of independence possible.

The third basic element of our policy is to assure the availability of a continuum of long-term care services with an appropriate mix and supply of individual services. Specifically what we would like to see is modest growth and replacement in the medical-residential sector or the nursing home element of the program; a greater growth in the nonmedical residential sector, congregate care facilities and adult family homes; and the most rapid growth in the community-based element of care.

We do not believe that it is practical to call for a reduction in the number of nursing home beds as a means of financing increases in either the community-based sector of care or the nonmedical institutional sector of long-term care programs. We feel that nursing homes are and will continue to play a very important role in the continuum of care. But we do not feel that the rate of growth among those three components ought to call for very modest growth in the medical institution sector, a more rapid growth in the nonmedical institutional, and the most rapid growth in the community-based elements of care.

The fourth element of our policy is to assure the quality of long-term care service is available in the State. This is a rapid-growth industry, if you will, and that sets up an environment where abuses can occur. I think it is very important that government keep an eye out for the quality of care, particularly in this type of situation.

The final element of our policy is to promote the appropriate placement and movement of individuals in, and the increased integration and coordination of, the long-term care continuum. Even with a full

continuum of services, there is nothing that is going to guarantee that people are appropriately placed within that continuum and properly moved through the continuum of services.

It is important that we develop those types of services like case management services that ensure that people are appropriately placed in the system and moved, when appropriate, from one segment to another segment of that continuum of care.

In recognition of these policies, the department has taken some very specific steps. Examples of these are the following:

First of all, we have adopted a revised nursing home bed projection methodology which calls for a reduction in the ratio of beds to population over the next several years. This policy has been incorporated into our certificate of need program and will be used by health planning bodies at both the local and the State level in the review of applications for replacement of and increased numbers of nursing home beds. So, we are taking steps to reduce the ratio of beds per 1,000 in the nursing home program.

Second, we have developed comprehensive case management standards to be used not only by the department, but also by the area agencies in the provision of case management services.

We have also developed a working agreement with the area agencies to make the best use of our combined casework staffs in the provision of case management services to both institutionalized populations as well as those long-term care clients residing in the community.

Another example is that we in this State do prescreen all medicaid nursing home applicants and are at present diverting about 20 percent of these applicants to alternative community care.

As Senator Evans mentioned, we do operate the COPES program, which is under the auspices of the Omnibus Reconciliation Act of 1981 and allows us to enjoy Federal matching in the provision of home-based services to persons who otherwise would be residing in nursing homes.

Basically, what we do is we screen clients who are on their way into a nursing home setting and attempt to establish a support system in their own home or, if not possible, then in a congregate care facility or an adult family home to maintain them in the community. And, provided that the cost of this care is at or below 90 percent of the cost of nursing home placement, we are able to enjoy Federal matching in the provision of those community-based services.

At the present time we have about 800 people enrolled in the COPES program, and this is far beyond our expectations at this point in time. So, we are very pleased with the progress of this program.

However, the COPES program has also provided us with a test kitchen for the attempt to combine what we consider to be a rational long-term care policy with some of the basic eligibility requirements of the Medicaid Program. We have become painfully aware of some of the incongruities between a progressive long-term care policy and the institutional biases of the Medicaid Program. A couple of examples of this incongruity. First of all, the $1,500 resource limitation, while it might be tolerable for a person who is a permanent resident of a nursing home, it is very onerous for a person who is maintaining their own dwelling. For a person living in the community, a $1,500 resource limitation can become prohibitive.

Another good example is the spend-down requirement in the Medicaid program where persons are required to spend all of their excess income and resources prior to becoming eligible for medicaid services. This creates several problems.

The first problem is that it is very difficult to manage. The process of identifying those expenditures that relate to the spend-down and keeping adequate records in order to establish eligibility can become very complex.

Second of all, it can lead to an off-again, on-again relationship with medical providers in that the providers become concerned about the particular source of coverage for care in any particular time. So, the spend-down requirement becomes a barrier to community placement in the long-term care program.

Based on our experience, we would make three basic recommendations for consideration by the committee. The first would be that consideration be given to developing a national perspective of long-term care. We think it is important that a common context be developed, that we have commonly shared services, objectives, and priorities so that we can make the best available use of those resources that are available. The system is going to command an enormous amount of funding regardless. And I think in order to foster confidence in the governments that are going to be expending these resources, it is important that we establish some common foundation in terms of what services are, what service priorities are, and what our objectives are.

Second, we thing it is important that consideration be given to developing organized funding and eligibility criteria. Not only are these myriad of programs with different funding sources and different eligibility criteria complex and difficult to unravel, they are also counterproductive because, as has been mentioned several times, there is tremendous institutional bias in the Medicaid Program which is not consonant with our perspective in terms of the direction that long-term care should be going.

I think it is important that we rationalize these funding and eligibility criteria such that they complement our service objectives in the area of long-term care.

In the short run, in order to make the maximum productive use out of the waiver program, such as COPES, we feel consideration ought to be given to establishing a more flexible eligibility criteria under the Medicaid Program; in other words, providing the opportunity for waiving some of the eligibility elements that I have referred to earlier so that we can reverse some of those biases that make it difficult to run the program as well as it could possibly be run.

With that, I would like to close and again thank you for the opportunity to provide you with this overview.

Senator EVANS. Thank you very much, Mr. Ferguson. I have several questions. Throughout your testimony, you talk about the eligibility criteria and some of the difficulties which flow from that. Would you suggest that we move toward a system that does not distinguish between medicare and medicaid, a system for all citizens over 65 that is uniform?

Mr. FERGUSON. I do not think that I was referring—or I had not really thought about not distinguishing between medicaid and medicare. I think what I was trying to refer to more was if we are inter-

ested in promoting a long-term care system that emphasizes the community-based side of the program, that we ought to align our eligibility criteria for programs such that there is no bias forcing a person into a nursing home situation when they could be maintained in the community.

And at present, under the Medicaid Program—for example, under the COPES waivers—the same eligibility criteria applies, the limited amount of resources that are allowed apply both to the community as well as to the residential setting. And of course a $1,500 resource limit can become very onerous for a person residing in their own home, who has to face unforeseen requirements from time to time. So, I think we need to align our eligibility criteria to complement the bias that we would like to see in the system. Whether that would ultimately lead to a single program for those over 65 is a separate issue that I have not considered.

Senator EVANS. Are there other biases regulations, or elements of statute beyond the ones of resources that also bias against some of these community programs?

Mr. FERGUSON. Another one that I made mention of was the spend-down requirement.

Senator EVANS. Yes, I understand that. But are there others besides those that you have mentioned this morning?

Mr. FERGUSON. Yes, there are. We could probably go down and tick off a substantial list of requirements in the Medicaid Program that do make a lot of sense in terms of placing people in a community. I would be happy to do that.

Senator EVANS. That would be very helpful to the committee, if you could provide that to us. It seems to me that is something we can get at. And to the degree that we are aware of those elements which prevent extensive use of appropriate community care, we should address them. If you could identify for us these shortcomings in terms of those which are regulatory problems and those which are statutory problems. That would be very helpful to the committee.

Mr. FERGUSON. I would be happy to. I would mention that I think it is kind of superficial to talk about simply removing eligibility requirements without at the same time talking about what type of controls we are going to use to control the costs of the program because there is a tremendous amount of latent demand for these services. I think being realistic about the funding that might be available makes it incumbent upon us to talk about how we are going to control access into the programs. And this is a very important element of the COPES program; the prescreening of clients to identify those that unquestionably are going to end up in a nursing home at public expense. And I think that if we try to modify the eligibility criteria to promote community-based care, at the same time we need to keep our eye on the requirement of properly screening clients to ensure that we do not just create an explosion in the demand for publicly funded services.

Senator EVANS. When you say, "Unquestionably going to end up in nursing home care," I am curious about how you are determining that now. Is it someone who is facing nursing home care immediately or some time in the next year? How much leadtime are you looking at?

Mr. FERGUSON. Immediately.

Senator EVANS. Immediately.

Mr. FERGUSON. These are people that have been referred to the department for placement in the nursing home setting.

Senator EVANS. I see. So, it is diversion from immediate placement.

Mr. FERGUSON. They are screened by our nursing staff and determined to be definitely eligible for nursing home placement.

Senator EVANS. Under the COPES program there are a variety of services available, I understand. To what degree does this differ from the Chore Service operation, which has been in existence for a good many years?

Mr. FERGUSON. Chore Service is really the foundation of the COPES program, because the majority of the people that are served under the COPES program are served in their own homes. One of the most fundamental service for clients residing in their own home is the Chore Service program along with home health care.

Senator EVANS. Do you have any difficulty in getting people to provide chore and other types of services, especially if this program is to continue to expand?

Mr. FERGUSON. Our Chore Service Program is really divided into two segments. One is the contracted program where we contract with organizations like Upjohn who in turn find Chore Service workers to provide the care. The other side of the program is the individual provider program where the Chore Service recipient themselves identifies and hires a Chore Service worker. To date, we have not experienced any significant difficulty on a statewide basis in terms of finding Chore Service workers. And we have had what I consider to be very good success in terms of maintaining the quality of the Chore Service workers under the contracted program.

Senator EVANS. I remember 10 or 12 years ago when we developed the program for local service here in the State, a program which encouraged young people to provide a year of voluntary service in a variety of ways. We, in essence, set up a trading post between young people who were offering volunteer service—although volunteer, it was a paid service—and those agencies and organizations which needed help of a variety of kinds. And, through a voucher system, we were able to get people together. Would that provide a significant source or could it provide a significant source for the kind of work that need to be done to keep people independent? In other words, could young people—17 to 20—provide a good many of those services under a volunteer program?

Mr. FERGUSON. We do have a volunteer Chore Service Program in this State. The legislature set aside a certain portion of the Senior Citizens Services Act funding specifically for a volunteer Chore Program. And this is provided largely through Catholic Community Services in this State. The program I think has been successful. It is important to point out the differences between the volunteer program and the basic Chore Program. We, over the last 3 years, as a result of cutbacks in State funding and Federal funding, have had to go through a series of restrictions in the Chore Service Program. So, a lot of the services that were provided originally under the Chore Program are no longer available. So, the care that is provided and the

people that are cared for under the Chore Service Program, it is much closer to home health care than it earlier was.

I am sure that there are young people that would be competent and interested in providing this kind of care. But it is not the friendly visiting type service that earlier may have characterized the program. So, it is fairly significant care that is provided under the Chore Service Program.

As far as using vouchers, that still places the recipient in the postition of identifying and dealing with the provider of care. And I think the contracted program has been very, very successful in terms of taking the recipient of care out of that difficult position of arranging for the care.

However, under the idea of a volunteer program, something to complement the voluntary program that we have in place, I think it would be a good idea.

Senator EVANS. I was not suggesting that the recipients have to go through the voucher program, but that an agency or group, providing for the recipient, work on a voucher system with the young volunteer.

Mr. FERGUSON. As I said, our volunteer program provides care at roughly $3.15 an hour. Those are fundamentally administrative costs as compared with over $5 an hour for the paid program. So, there are some economies that can be experienced. And I think anything to promote the voluntary sector or the informal care system is a step in the right direction.

Senator EVANS. Have you analyzed the potential expansion of COPES to determine whether it has potential long-term economic as well as health benefits if it were to be extended beyond just those who are immediately facing reference to a nursing home to those who are struggling but not quite at that point?

In other words, if we were to provide some home assistance earlier, could that result in people being independent for a substatnially longer period of time?

Mr. FERGUSON. I think the answer to your question is yes. In terms of the economics, I think it becomes a question of a point of reference. There is no question that Government at all levels faces budget problems in terms of financing the increased costs of the long-term care system. And broadening the program undoubtedly is going to increase the amount of the latent demand or increase the access of the latent demand to the system, and costs are going to increase. In the long term, whether that provides us with a reduction in costs by avoiding more extensive care again depends upon your point of reference. With a limited number of nursing home beds available, a limited number of acute care beds available, to some degree we can ignore those costs because of the limitations of brick and mortar. But in a broader frame of reference, I do not think there is any question that preventive care can be successful in staving off the need for more acute care.

Senator EVANS. When you say you can ignore such cost because of the lack of bricks and mortar, I guess that is speaking on the economic side. It does not speak as well to the health side——

Mr. FERGUSON. Not at all.

Senator EVANS [continuing]. Or the needs of people——

Mr. FERGUSON. Not at all.

Senator EVANS [continuing]. Which we really have to try to get at.

Mr. FERGUSON. That is quite correct.

Senator EVANS. Thank you very much for your testimony. We would appreciate having those additional elements because I think the information will point out one thing we can do, and can do fairly promptly: work toward reduction of those statutory and regulatory barriers that keep us from doing a responsible job.

Mr. FERGUSON. I would be happy to supply that.

Senator EVANS. Thank you.

Mr. FERGUSON. Thank you.

[Subsequent to the hearing, the following letter was received from Mr. Ferguson:]

JOHN SPELLMAN
Governor

KAREN RAHM
Secretary

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
Olympia, Washington 98504

July 24, 1984

The Honorable Daniel J. Evans
United States Senator
SH-702 Hart Senate Office Building
Washington, D.C. 20510

Dear Senator Evans:

At the Senate Special Committee on Aging hearings in Seattle you asked me to provide specific Medicaid regulations that have an institutional care bias and, therefore, affect the care provided to recipients under the Home and Community-Based Care Waiver Program. I have identified two primary regulations which I feel should be changed so that care in the home can be comparable to care in an institution.

1. 42 CFR 435.232 - Individuals Receiving Home and Community-Based Services Who Are Eligible Under A Special Income Level.

   These income rules tie into the SSI resource level of $1500 for a single person. Most COPES clients are elderly persons with limited resources. They often have had to spend down or transfer their resources to become eligible for services. In a nursing home, a $1500 resource limit may be reasonable since the institution is responsible for the client's total needs. However, in the client's own home, he or she must pay for repairs, lawn and home maintenance and losses from accident or theft. These repairs could often exceed $1500. The cost of maintaining a home and living in the community can be persuasive in the client's choice of nursing home care over care in the home.

2. 42 CFR 435.726 - Post-Eligibility Treatment of Income and Resources of Individuals Receiving Home and Community-Based Services Furnished Under a Waiver. Application of Patient Income to the Cost of Care.

   A recipient of home and community-based care services should participate in the cost of his or her care. The application of all excess income over the medically needy income level, however, is more than most clients can afford and still maintain the minimum standard of living. The medically needy income level for one person in Washington State is $353 per month. Anything over this amount is contributed to the cost of care. The typical COPES recipient is a woman over 70 years of age living alone. She has to pay for many of the same services and utilities which we do. Sometimes she rents. She may have to pay for a special diet or other "conveniences" such as a wheelchair accessible apartment. More money should be available

for home and community-based care clients to pay bills and other daily living expenses which are routinely covered in the nursing home.

In addition to these rules, there are two rules that restrict program administration.

42 CFR 441.302 - State Assurances.

Paragraph (a) - This rule assumes that the providers of waivered services are established businesses, the same as nursing homes or home health agencies. While the department does have licensing standards for some services such as adult family homes, most clients receive personal care in their own home and the majority of the personal care providers are individuals - independent contractors. These providers form an informal network of assistance for the client. In these cases, the accountability for quality care and provided services should be shifted from the personal care provider to the case manager.

Paragraph (d) - The department agrees that client choice of services is important. However, it is equally important that public cost be considered in developing a plan of care; and whenever a client requests nursing home care over community care, even though community care is determined to be cheaper, the state should be allowed to provide the services which are most cost effective.

Thank you for the opportunity to communicate these concerns directly to you. Overall, the department has been very satisfied with its Home and Community-Based Care Waiver. I feel that these small changes to the Medicaid regulations would make the program even more valuable to our clients.

Sincerely,

Bruce Ferguson

BRUCE FERGUSON
Assistant Secretary
Community Services

Senator EVANS. I would like to call up the next panel.

Would Anne Katterhagen, executive director of the Tacoma Hospice and Home Health Agency; Karen Wintringham, assistant to the senior vice president, Group Health Cooperative of Puget Sound; Daniel Wagster, senior vice president and regional manager of Kaiser-Permanente of Portland, OR; and John Haugan, president, the John Tenten Group, Full-Program Retirement Residences, please come forward.

This panel is a panel of professionals in the field and can tell us of a variety of alternatives in health care.

I would ask that each witness go through their oral testimony before we get to questions. Mrs. Katterhagen is the executive director of the Tacoma Hospice and Home Health Agency. She has served on the Governor's Task Force for Health Planning and is currently a member of the Governor's Task Force for Health Care Cost Containment. She is on the board of directors of the National Association of Home Care and the Home Care Association of Washington and the Pierce County Health Council. As an administrator involved daily with Federal, State, and local jurisdictions concerning the provision of long-term health care, we look forward to your testimony and to the assistance you can give the committee.

STATEMENT OF ANNE KIRCHNER KATTERHAGEN, TACOMA, WA, EXECUTIVE DIRECTOR, HOSPICE OF TACOMA

Mrs. KATTERHAGEN. Thank you, Senator Evans. I am the founder and executive director of Hospice of Tacoma, a health care organization providing hospice services, home health services, and adult day health care to elderly citizens of Pierce County and South King County. I will be speaking from the frustrations of providing community-based services within Pierce County.

First, I would like to thank you this morning for inviting me to testify here today, and especially for holding this hearing. The three programs I administer utilize a multitude of funding sources in order to provide services to the elderly, including title XVIII, medicare, title XIX, medicaid, title XX, Institute on Aging, many private insurances, United Way funding, revenue sharing moneys, and block grants.

In 1982, we provided services to over 900 citizens of Pierce County. The difficulties in providing service to the elderly are many. They appear to arise from two areas.

First, the fact that each entitlement is separate, has its own bureaucratic system to administer it, therefore encouraging the separateness of the services.

Second, within the medicare system there is a tightening of service guidelines to where services that were allowed a year ago are today being denied. This tightening is occurring without going through the process of regulatory change.

I will confine my testimony to these two areas.

The Health Care Financing Administration (HCFA) contracts with fiscal intermediaries such as Blue Cross or Aetna, to administer the Medicare Program within a region or a State. These intermediaries interpret the medicare regulations for providers frequently on

a retroactive basis. These interpretations in the home health area are inconsistent across the country, creating situations where a service may be allowed in one State and denied in another. As these increasingly restrictive interpretations of the medicare system continue, soon the elderly will be ineligible for treatment because their diseases will be defined as chronic or, too acute for home care, but not acute enough for inpatient care in a hospital.

Chronic care is not allowed in the medicare system. Yet because of technology, more and more diseases are chronic. For instance, individuals with Alzheimer's disease—a disease that can be stable, chronic, or can progress rapidly downhill to death—is frequently denied service under medicare and title XX. The only system available today for the provision of chronic care happens to be medicaid. However, a family must exhaust all of their resources in order to obtain this benefit.

I would like to give you an example currently occurring today in Pierce County of the problem with interpretation by an intermediary in the area that I have spoken of. Our organization is currently providing service to a 72-year-old gentleman who had been healthy all of his life until a year ago when he began having back pain. After seeing his physician, he was hospitalized and diagnosed as having cancer of the prostate—by the way, frequently a very slow growing cancer. This cancer of the prostate had metastasized to his backbone and encased his spinal cord. The cancer was removed, and he returned to his home although he was paralyzed from his lower back on down.

Our home health program began to provide nursing services to him in his home, to teach the care giver how to take care of a paralyzed person, recognizing that whether he would walk again would be problematic. The physician felt that there was a chance that he could recover and resume his active life. After 6 months of continuous service, such things as bowel and bladder training and the numerous other problems of paralysis, the gentleman began to have feelings in his lower limbs.

At this time, the physician ordered a physical therapist to visit the patient at his home three times a week because the patient was unable to walk and therefore homebound. The physical therapist worked with the gentleman as ordered, and is continuing to work with him today. The formerly paralyzed patient is now able to walk to his kitchen with the use of canes. However, payment for services to this gentleman is being denied today through medicare because, in the words of the intermediary, the gentleman is not showing progress.

A man who is diagnosed with cancer, coming home from the hospital, paralyzed from his waist down, and after treatment is able to walk to his kitchen, is denied service in the medicare system because he is "stable."

Constructions of benefits for the elderly appear to have been done in complete isolation from already available services. We have three separate systems of care for people over 60. They include the medicare system, the medicaid, and the aging system, all of whom, as I said, have separate regulations for entry and continued service provision plus separate administrative structures. It appears that this failure to coordinate benefits at the initation has resulted in creation of gaps in service delivery.

An example of the gaps in the system is demonstrated by another story of two women, both over 80 years old, living next door to each other in South Tacoma. One of them was hospitalized recently with a severe bleeding peptic ulcer. After hospitalization, she was sent to a nursing home for rehabilitative care. As an aside here, I would like to point out that Pierce County, for whatever reason, tends to utilize nursing home care much more than community-based care, a problem that I would like to deal with some time.

After approximately 1 month of nursing home care, she was returned to her home under the care of our home health agency. Skilled nursing needs at this time are minimal in assisting her in gaining strength and relearning her walking skills, plus monitoring her hemoglobin and hematocrit to monitor her anemia. Since, however, her nursing home care was not covered under medicare—for what reason, I am not sure—this particular lady had utilized all of her savings down to $200. Since she continues to need assistance with personal care and is in danger of reinstitutionalization, she became eligible for the COPES program and was referred to it in late May, with a contract signed at that time. It is now the 1st of July. The woman still has not received any reimbursement from the COPES program although she hired a housekeeper in early June, upon the recommendations of the COPES staff that she would receive payment.

As of today, she has $76 left in the bank, and while approved for medicaid and COPES, the admission to the system is so slow that she has received none of the reimbursement for such.

The new medicare hospice benefit is another example of the failure to coordinate benefits with those of already existing services. This is demonstrated by the lack of participation in the new medicare benefit by existing hospice programs. The Joint Commission on Accreditation of Hospitals estimated there were 1,400 hospice programs in the United States at the enactment of the benefit in 1982. As of last week, there were only 77—who had elected to participate in the Medicare Hospice Program. The reasons for lack of participation include the inadequate reimbursement mechanism, the inability to secure the management control of inpatient services as required in the legislation. Even the 26 demonstration projects are reluctant to become certified under medicare for the hospice benefit.

This fractionation of care caused by the creation of multiple systems providing services to a single elderly person is extremely complex, frightening, and confusing for the elderly to participate in, let alone seek entry to.

For instance, the 84-year-old lady that I mentioned, still in fragile medical health, is now eligible for medicare and medicaid home health, Chore, and COPES, providing personal care in the home. Which program is appropriate depends upon the degree of illness, or lack of illness, of the client, something too complex for the elderly to comprehend.

In my view, a good system of care to provide services to the elderly would involve an integration of the entitlement programs at the Federal and local level, plus consistent fair regulation of services. Also involving the private side in developing innovative ways of service delivery. The ideal system should have multiple entry points located in familiar accessible locations such as physicians' offices or

hospitals, with appropriate incentives to utilize community-based services.

Utilization of a computer, for instance, to determine appropriate services could eliminate some of the access problems and possibly eliminate duplication.

The vertical integration of the health and social system into a single delivery system with multiple entry points at familiar locations would appear to close many of the gaps I have discussed today.

Thank you for giving me the opportunity to testify today. I'll be happy to answer any questions you may have.

Senator EVANS. Thank you very much. You suggested a number of questions, and we will get to those as soon as the panel has completed its testimony.

Next, Karen Wintringham from Group Health Cooperative of Puget Sound. She has been with Group Health for the last 6 years, where her primary responsibility has been to determine and address the effects of Federal and State reimbursement policies on the care of elderly and the poor at the Cooperative. We look forward to hearing about what is going on today at Group Health and welcome your testimony.

STATEMENT OF KAREN WINTRINGHAM, ASSISTANT TO THE SENIOR VICE PRESIDENT AND CHIEF FINANCIAL OFFICER, GROUP HEALTH COOPERATIVE OF PUGET SOUND, SEATTLE, WA

Ms. WINTRINGHAM. Thank you, Senator Evans. I appreciate the opportunity to speak on behalf of Group Health Cooperative before this hearing of the Senate Special Committee on Aging. I am Karen Wintringham, assistant to the senior vice president and chair of the cooperative's steering committee on long-term care.

As you are well aware, the cooperative is a consumer-directed health maintenance organization, providing comprehensive health care services to some 330,000 individuals in the Puget Sound area. The Cooperative has established itself as a leader in providing comprehensive, high quality, affordable health care to approximately 30,000 enrolled Medicare beneficiaries. On July 1, 1966, we became one of the first medicare providers in the country. In October 1976, the Cooperative became the first and only health maintenance organization to participate in the medicare incentive reimbursement program authorized by section 1876 of the Social Security Act.

I would add that our successful performance under that contract undoubtedly promoted passage in December 1982 of true prospective risk reimbursement for HMO's, although regulations implementing that provision have not yet been finalized.

Under our risk-sharing program, the cooperative consistently provides comprehensive medicare benefits for 76 to 80 percent of community reimbursement levels. From 1976 through 1981 the cooperative generated savings in excess of $17 million. Approximately $9 million have been returned to the Social Security trust funds. The remaining $8 million have been used to reduce monthly premiums paid by our medicare enrollees.

The principles, as you pointed out earlier, of the Federal Medicare Program reflect the incentives and the organization of the traditional fee-for-service medical community. What the risk-sharing program attempts to do is to adapt that fee-for-service orientation to the very different incentives and organization of health maintenance organizations. With great effort and prolonged negotiations, some adaptations have been made. It is our hope that with the eventual implementation of the prospective risk program authorized by the Tax Equity and Fiscal Responsibility Act, that HMO incentives will be incorporated more completely and other plans will choose to participate.

Although the cost-conscious incentives of HMO's have been incorporated into medicare risk contracts, other Federal regulatory provisions preferentially undermine the HMO incentives. In my written testimony I elaborate on examples covering end stage renal disease, the exclusion of some categories of HMO patients from risk reimbursement, changes of beneficiares' primary coverage from Medicare to employers' health plans, institution of DRG-based hospital reimbursement, and release of proprietary information through the contracting of reviews to fiscal intermediaries.

My testimony also outlines the findings of our steering committee on long-term care as it considered how best to serve a population with increasing use of services and chronicity of illness. We will continue our efforts to respond to these needs through a private-sector consumer partnership. However, it is clear to us that Federal and State legislative reform must be added to that partnership. I would like to suggest several components which, from our perspective, would encourage a more efficient and effective system.

First, medicare, medicaid, and other public funds supporting care of seniors must be integrated under a coordinated set of rules.

Second, HMO's and other forms of managed health care systems cannot assume all the risk inherent in care for chronically ill patients. Other providers must be encouraged to develop more efficient models of care for senior populations.

Third, incentives to encourage efficiencies in the fee-for-service community should not undermine the HMO's incentives.

Fourth, providers should have maximum flexibility to determine creative, effective new ways to provide services.

Fifth, the concept of a medicare part C should be reconsidered. Only with the addition of social and support services can more chronically ill beneficiaries maintain independent life styles and avoid the costly alternative of institutionalization.

And finally, we must recognize that even with new incentives and efficiencies, the demographic trends mean that expenditures will increase. We believe, however, that with our suggested changes in Federal policy, the rate of increase will be moderated and the quality of those expenditures will be enhanced.

Group Health Cooperative's leadership will continue as it adapts to meet the changing needs of an aging population. However, Federal and State policy initiatives must recognize and nurture the unique incentives of HMO's and other rational models of care. Together we can encourage independent life styles, maintain the dignity of our seniors, support the invaluable aid of their friends and families, and promote high-quality, fiscally responsible systems of care.

Thank you very much.

Senator EVANS. Thank you. Your prepared statement will be incorporated into the record.

[The prepared statement of Ms. Wintringham follows:]

PREPARED STATEMENT OF KAREN WINTRINGHAM

Senator Evans, I appreciate the opportunity to speak before this hearing of the Senate Special Committee on Aging.

I wish to speak on behalf of Group Health Cooperative of Puget Sound, as assistant to the senior vice president and chair of the Cooperative's Steering Committee on Long-Term Care. My comments will focus on the Cooperative's truly remarkable history and leadership efforts to provide comprehensive, high quality, affordable health care to a senior population. The Cooperative's more recent initiative to reevaluate our programs in the light of the unprecedented growth and aging of our society forecast for the next 20 years provides additional findings of interest. Finally, I will suggest potential legislative initiatives which may help insure the success of any Federal-State-private partnership to promote healthy independent lives for our elders while assuring fiscal responsibility in the associated governmental programs.

HISTORICAL PERSPECTIVE

On July 1, 1966, Group Health Cooperative became one of the first medicare providers in the country. At that time, it seemed appropriate that we try to reduce out-of-pocket premiums for our elder enrollees by incorporating their medicare entitlement. However, the Cooperative quickly recognized that the voluminous statutory and regulatory language governing the medicare program was not written to reflect the efficiencies inherent in health maintenance organizations [HMO's]. Rather, the program incorporates a fee-for-service medical model with care delivered in unrelated, independent hospitals, nursing homes, physicians' offices, and home health agencies by unrelated, independent practitioners.

For many years, the Cooperative negotiated with the Social Security Administration to try to achieve some adaptation of medicare rules to reflect the incentives inherent in an HMO. Finally, in October of 1976, the Cooperative became the first risk basis medicare program in the Nation. One might imagine the struggle of trying to implement a special program for some 13,000 medicare beneficiaries in Seattle while the Social Security Administration administered a uniform program for millions of beneficiaries nationwide. The years of explaining what an HMO is, how it works, why its enrollees should follow a different set of rules continue. However, the Cooperative succeeded in providing comprehensive health care to an enrolled population of medicare beneficiaries. The plan consistently provides care at 76 to 80 percent of medicare reimbursement levels in the community. Indeed, our success contributed to the passage in December of 1982 of revisions to the section 1876 authority, enhancing the concept of medicare incentive reimbursement for HMO's and competitive medical plans [CMP]. We would certainly encourage every effort to hasten the delayed implementation of that program as a means of encouraging managed systems of health care to expand their cost effective incentives to encompass senior populations.

RISK BASIS REIMBURSEMENT 1972-82

Risk basis medicare reimbursement incorporates four primary elements:

(1) Risk.—The HMO commits itself to cost less than the fee-for-service community. The medicare program will not pay for any costs in excess of the community level of reimbursement, defined as the adjusted average per capita cost [AAPCC].

(2) Incentive.—If the HMO is able to provide medicare benefits at a cost below that of the community, it shares with the Federal Government the "savings" generated (to a maximum of 10 percent of community costs).

(3) Lock-in.—As in the traditional HMO model, medicare beneficiaries enrolled under a risk contract must use the HMO's facilities and practitioners. Medicare will not cover any care provided outside the HMO unless referred by the plan or unless it qualifies as urgent or emergent care.

(4) Open enrollment.—For at least 30 consecutive days each year the plan must enroll all applicants on a first-come, first-served basis.

As one measure of success, table 1 documents the Cooperative's cost performance relative to the community.[1]

TABLE. 1.—*GHC adjusted medicare costs as a percent of community reimbursement levels [AAPCC]*

Year:	Percentage
Oct. 1, 1976, to Dec. 31, 1977	67
1978	[1] 84
1979	[1] 89
1980	85
1981 [2]	78
1982 [2]	79
1983 [2]	76

[1] Years of a special demonstration program waiving the Lock-in provision.
[2] Not yet final figures, subject to change.

It should be noted that from 1978–80 the Cooperative participated in a demonstration authorized by section 222 of the Social Security Act. Under the experiment, the lock-in provision was waived, allowing beneficiaries to seek care wherever they chose. Clearly, the lock-in assures the plan and its enrollees the financial savings generated by the HMO's closed system and control of services.

A second measure of success focuses on savings generated. Table 2 documents incentive payments to GHC of approximately $8 million through 1981; the Federal Government's share of savings exceeded that amount. Current estimates of the Cooperative's share of savings for 1982 exceeded $4 million.

TABLE 2.—GHC MEDICARE SAVINGS GENERATED

Year	Savings	Per member per month
Oct. 1, 1976, to Dec. 31, 1977	$1,306,727	$6.27
1978	1,067,121	5.40
1979	955,566	4.37
1980	1,801,134	6.86
1981	3,174,000	11.26

Use of the savings under GHC's contract remain unspecified. However, the Cooperative has elected to use these funds to reduce the financial obligations of the plan's medicare enrollees. Monthly premium reductions have ranged from $4 to $11 per month, as noted in table 2.

The existing model incorporates advantages and disadvantages which differ for each of the participants:

(1) The Federal Government is guaranteed a cost level below that of the community but is paying more than the HMO's *costs* to encourage the plan to care for medicare beneficiaries.

(2) The beneficiary is guaranteed a fixed monthly premium for comprehensive health care benefits. No coinsurance or deductibles are collected, and no catastrophic bills exist. The plan handles all filing of paperwork with medicare. In addition, any cost efficiencies generated by the HMO result in premium reductions for the beneficiary. The beneficiary, however, does waive the freedom to seek care outside the plan. In addition, beneficiaries may have to leave established relationships with community practitioners, although in many cases the practitioners also have retired from practice.

(3) The advantages to the HMO are less obvious. If the plan is committed to caring for seniors, risk reimburseemnt does provide the greatest flexibility with medicare's fee-for-service rules. In addition, savings generate are at least partially retained by plan enrollees rather than returned to the Government for use in funding less efficient programs.

From the Cooperative's perspective, the major disadvantage of our current program is the lack of true prospective payment. Retroactive adjustments to the AAPCC have delayed settlement of savings as much as two to three years. This, in turn, delays the plan's ability to return the savings to its emrollees in a timely fashion. The delays also inhibit the plan's ability to budget prospectively, one element essential to the success of an HMO.

[1] Adjusted for demographic factors such as age, sex, institutional status, and disability.

HMO PROSPECTIVE REIMBURSEMENT

One provision of the Tax Equity and Fiscal Responsibility Act of 1982 authorized truly prospective medicare reimbursement for a broader range of managed health care systems. The provisions, commonly referred to as 95 percent reimbursement, incorporated many of the elements of the Cooperative's program. It also attempted to address the major limitation of the prior statute by removing the practice of retrospective adjustments to the AAPCC.

In addition to establishing prospective capitated reimbursement, the new legislation also alters the payment level. Participating plans are paid 95 percent of the community reimbursement level, the AAPCC, regardless of the plan's costs. Table 3 depicts differences in reimbursement levels under the two programs. Risk increases for less efficient plans and savings increase for more efficient plans.

TABLE 3.—CALCULATION OF HMO SAVINGS SHARE UNDER ALTERNATIVE RISK MANAGEMENT

	Community reimbursement	Current GHC savings	95 Percent savings
Group Health Cooperative:			
$80	$100	$10	$15
$70	100	10	25
$90	100	5	5
$100	100	0	−5
$110	100	−10	−15

Unfortunately, efforts to draft regulations to implement the 95 percent reimbursement program have progressed more slowly than expected. Draft regulations released May 25, 1984 are not anticipated to be reissued in final form prior to September 1984. In the meantime, a matching provision in the new law specifically encourages plans to delay enrolling beneficiaries until the prospective payment program begins.

COMPARISON OF TWO PROSPECTIVE PAYMENTS MODELS: THE AAPCC VERSUS DRG'S

Several months after the passage of TEFRA, containing the 95 percent reimbursement program, the Social Security Act was reamended. The amendments established a form of prospective medicare payment for community hospitals adjusted for 467 different diagnoses (DRG's). As has occurred previously with alarming frequency, the provision selectively disadvantages HMO's. Ironically, the provision intended to incorporate some of the HMO's incentives into the fee-for-service practice of medicine, not to undermine those incentives.

Under traditional medicare cost reimbursement, hospitals might generate an infinite variety of charges. Each bill would vary by the specific treatments, services, and supplies used on each patient. Reimbursement incentives rewarded increased treatments, services and supplies and failed to reward efficiencies.

DRG-related prospective reimbursement attempts to narrow payment levels to 467 DRG's plus some adjustments for unusual circumstances. Payment for treatment of any particular diagnosis does not reward "more." In fact, hospitals retain any savings generated by treating a patient for a cost below the specified DRG.

The evolutionary pattern of prospective reimbursement, then, progresses from unlimited payment types to 467 DRG's to the single capitated payment of 95 percent of the AAPCC. The latter, the most highly developed model, includes all services available to an enrollee rather than separately reviewing each component, such as the hospital bill.

The ultimate model of a single capitated payment accomplishes two major objectives: (1) Plans are disadvantaged by providing unnecessary services, and (2) Plans have maximum incentives to determine the most effective and low cost site and mode of treatment. The result tends to favor enhanced use of alternatives to institutional, particularly hospital, settings. In fact, research consistently documents cost savings achieved by HMO's result from reduced hospital admissions, shorter lengths-of-stay in hospitals, and increased use of outpatient services.

As mentioned earlier, the attempt to begin applying prospective payment to the fee-for-service community unintentionally disadvantaged HMO's. The following briefly summarizes the effects:

(1) Although HMO's typically reduce hospital lengths-of-stay, HMO's purchasing hospital care will be paying average DRG levels. The New Jersey DRG experience documented substantially increases in costs paid by HMO's with no change in services used.

(2) HMO's participating under risk reimbursement and purchasing hospital care in the community will experience increased risk. On average, for each hospital admission the HMO will be receiving 95 percent payments from medicare but will be paying the hospital 100 percent of the DRG.

(3) In the case of hospital-based HMO's, the DRG legislation applies to care not provided under 95 percent reimbursement. It appears, for example, that GHC will have to incur the costs of instituting an entire DRG system for the few individuals treated in GHC hospitals but not enrolled in the risk program.[2] This seems particularly inconsistent since the patients are treated under the same incentives and by the same practitioners as risk enrollees. Furthermore, efforts are being made to make hospital-based plans submit data equivalent to the fee-for-service community; under the incentives the data will be "unequal" and, more importantly, irrelevant for the purposes of reimbursement.

Provisions selectively disadvantaging HMO's are likely to do so unintentionally. Other examples include but are by no means limited to the following:

(1) Changes in reimbursement of end stage renal disease shifted medicare from a primary to a secondary payor for the first 12 months of eligibility. HMO's generally had to pick up 100 percent of the shift, averaging some $30,000 per beneficiary. Other insurers picked up less than 80 percent of the cost.

(2) Changes authorized by TEFRA shifted medicare coverage from primary to secondary for employed beneficiaries 65 to 70 years of age. Employer plans encourage enrollment of these beneficiaries in HMO's which raise premiums for the younger employees. In turn, younger employees then shift coverage to other insurers. In addition, the provision may force the youngest, healthiest participants off the risk contract.

(3) Some individuals are precluded by statute from participating in the risk-sharing program. They may be treated in our facilities by our practitioners under the same ncentives as the risk enrollees. However, the Health Care Financing Administration believes we need to implement an entire DRG tracking system for those few individuals.

With infrequent exceptions, legislative and regulatory medicare provisions forget the potential impact on HMO's, particularly on risk-basis HMO's. The perverse outcomes tend most severely to affect risk basis hospital-based HMO's such as the Cooperative's.

HMO RESPONSIBILITIES BEYOND MEDICAL CARE FOR A SENIOR POPULATION

To date, the Cooperative's involvement in care of medicare beneficiaries has focused on meeting medical needs. The benefit packages and reimbursement methods enhanced the medicare coverage levels. However, enrollment of a sizable senior population, forecast demographic changes for our elder citizens, and attendant high use rates inevitably suggest the need at least to consider whether the plan's role should expand.

Seniors have participated actively throughout the development of the Cooperative's risk basis program. Their participation encouraged the establishment of the following:

(1) Enhanced education programs for medical staff, nurses, and administrative personnel on care of senior enrollees,
(2) A directory of community resources,
(3) A routine footcare program,
(4) Special education programs for seniors, and
(5) A hospice program.

Management and medical staff initiated significant changes, focused primarily on increasing staffing levels, purchased care and several specialty services. Services and programs currently provided are listed in appendix A.

The reconsideration of GHC's senior program begun in 1983 has resulted in the synthesis of voluminous information. However, fairly significant gaps in the available literature result in an incomplete description of the needs of an elder population. Nonetheless, dramatic changes in the influetnce of seniors will accompany the equally dramatic demographic changes that approach.

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[2] This would include private patients (mostly emergency care) and enrollees not qualified to participate in the risk program.

The Cooperative's deliberations have identified eight major findings, applicable to a wide range of health care settings:

(1) *The elder population is growing as well as aging*, reflecting the size of the cohort entering their 65th year as well as significantly increasing life expectancies.

(2) *Use of services within the Cooperative is increasing* on a per capita basis. This results from increasing numbers of seniors, aging of the population, and changes in patterns of use.

(3) *The senior population is not homogeneous.* Rather, the use rates and services needed very dramatically within the category. Although vigor may extend throughout life, an average individual's needs for services and chronicity of illness increase with age. Table 4 briefly depicts the significantly higher use of GHC hospital care accompanying aging of a population.

TABLE 4.—*Relationship between age and hospital use per thousand*

Age category:	*Days per thousand*
65 to 74	1,426
75 to 84	2,773
85+	3,823

(4) *The costs of caring for seniors increase while traditional methods of reimbursement are threatened.* Certainly the imposition of DRG reimbursement reflects just the beginning of Federal efforts to restrict medicare payments. Additional efforts inevitably will constrain the AAPCC and increase out-of-pocket expenditures of seniors.

(5) *Placement of seniors at the most appropriate and most cost effective site requires access to a broader range of services than that required for a younger population.*

(6) *Community social and support services consist of a vast array of independent entities rather than a fully integrated system of care*, and

(7) *Financing options for social, support, and custodial services are fragmented and inadequate.* Frequently, families and individuals cannot afford these services, particularly $2,000 to $3,000 per month for nursing home care. Furthermore, funds available from such sources as medicare and medicaid are not coordinated. Invariably the choices allowed by each program's distinct set of rules provides less efficient, more costly approaches than could be accomplished under an integrated program.

GHC has launched a Cooperative-wide discussion of the above findings. The approaches established to address the greater and different needs of a senior population must be tailored to each individual setting. They must address very difficult issues including what mix of services would be most efficient and what combination and use of practitioners can best care for an elder population. We believe all health care programs must act now to gain consensus on how best to address the inevitable and dramatic changes that approach. And although we support the responsibility of each private sector program to commit itself to responding to the needs, we also recognize the inevitable responsibilities and involvement of Federal and State governments.

PROPOSED LEGISLATIVE AND REGULATORY REFORMS

One of the major purposes of the 99th Congress will be to reduce the Federal deficit. That process will not overlook the dramatic effect of entitlement programs both on the deficit and the general economy. Careful consideration must be given to proposals which instill incentives to meet commitments made by entitlement programs in a more cost effective manner. We believe that with public sector assistance to modify existing incentives, savings achieved by HMO's in medical care can be expanded to encompass more efficient long term care services. Without careful deliberation, even current savings and incentives may be undermined.

Although the Cooperative has not yet determined its future direction in caring for a senior population, our experience under risk reimbursement suggests certain principles critical to the success of any model. In addition to principles GHC must incorporate, we would suggest the following components which, from our perspective, would encourage a more efficient and effective system:

(1) Medicare, medicaid, and other public funds supporting care of seniors must be integrated under a coordinated set of rules if cost efficient and service effective care is to be achieved.

(2) HMO's and other forms managed health care systems will survive only under conditions of average risk. These plans can achieve significant savings. However, these plans cannot assume all of the risk of caring for chronically ill patients. Other providers must also be encouraged to develop more efficient models of caring for senior populations.

(3) Initiatives to modify incentives among non-HMO providers should not undermine the efficiencies already achieved by HMO's. The differential impact of regulatory or legislative reform on different models of care must be recognized.

(4) Providers and organizations at risk should have maximum flexibility to determine creative, cost-effective new ways to provide services.

(5) The concept included in previously drafted proposals for a part C of medicare deserves reconsideration. Only with the addition of social and support services can more chronically ill beneficiaries maintain independent lifestyles and avoid the costly alternative of institutionalization.

(6) Finally, the demographic trends must be recognized. Current programs can be made more efficient and, concomitantly, less costly by encouraging appropriate incentives. However, despite those improvements, the aging of the population inevitably will increase expenditures. Improvements may serve to moderate the rate of increase and improve the quality of those expenditures.

SUMMARY

This country is about to witness changes in our population never seen before, with unprecedented growth and aging of the population. We must anticipate these changes and begin to instill incentives which encourage independent lifestyles, maintain the dignity of our seniors, support the invaluable aid of their families and friends, and promote high quality, fiscally responsible systems of care. The responsibility for achieving these purposes does not rest solely with the Federal Government. Rather, through a sensitive partnership of citizens, and the private and public sectors, innovative programs will be developed.

Group Health Cooperative of Puget Sound has established itself as a leader in caring for a senior population. It's leadership will continue and will flourish if Federal and State policy initiatives recognize and nurture the unique incentives of HMO's and other rational models of care. Creativity will be required to adapt to the dramatic change in needs forecast for the coming decades. By instilling effective incentives and recognizing local diversity, the tremendously creative pluralism of our society will meet those needs.

Appendix A

Current GHC Services Available to Elder Enrollees

All medicare covered benefits.
Hospital social service program.
Transportation among GHC campuses and medical centers.
Discharge planning.
Mental health services.
Eye care to GHC patients in nursing homes—provided on a voluntary basis by GHC providers.
Routine foot care.
Hearing aid dispensary paid on a fee-for-service basis.
Nutrition counseling.
Alcohol and drug abuse program.
Senior Wellness program.
Senior Caucus.

Senator Evans. Our next participant is Daniel Wagster, the senior vice president and regional manager of Kaiser-Permanente of Portland. Mr. Wagster has been with Kaiser since 1957, serving in a variety of different managerial level positions. Unlike the Group Health HMO, Kaiser-Permanente of Portland has been designated as a demonstration site, one of four in the Nation, for the social/HMO experiment. We would be interested in learning about your demonstration project as well as its similarities and differences from the traditional medical HMO organization. Mr. Wagster, I look forward to your testimony.

STATEMENT OF DANIEL O. WAGSTER, PORTLAND, OR, SENIOR VICE PRESIDENT AND REGIONAL MANAGER, KAISER FOUNDATION HEALTH PLAN OF OREGON

Mr. WAGSTER. Thank you, Senator Evans. It is a pleasure to be here in Seattle today. Although I am living in Portland these days, I was born in Port Angeles and went to high school in Kelso. I have always been proud of Washington as my home State.

I am also proud of my long association with the Kaiser-Permanente medical care program. We are a group practice, prepayment, health maintenance organization. We serve about 270,000 people, of which some 26,000 are 65 years or older living in the Portland-Salem, OR, area and Vancouver, WA. We plan to expand to the Kelso-Longview area this fall.

Since offering our program to the public after World War II, Kaiser-Permanente has grown to about 4½ million members, voluntarily enrolled, across the country in nine regions today. Kaiser Foundation Health Plan and Kaiser Foundation Hospitals are nonprofit corporations which combine with the Permanente medical groups to form the largest nongovernmental medical care delivery system in the United States—the Kaiser-Permanente Medical Care Program.

A unique feature of the Oregon region is its nationally recognized health services research center, which has played a role in pioneering projects that successfully demonstrated it is possible to provide quality medical care at a savings both to medicare beneficiaries and to the Medicare Program.

In 1978, HCFA awarded to our research center one of seven demonstration contracts to test the feasibility of increasing enrollment of medicare beneficiaries in HMO's.

The first objective of the Portland demonstration was to design a prospective payment system which included sufficient incentive to beneficiaries for them to enroll, which would cost the Medicare Program less than fee-for-service payments and which would provide appropriate payment to the HMO. We called it medicare plus.

Under this demonstration the monthly payment by HCFA includes a contribution toward the cost of supplemental benefits, plus payment for special new member services. These additional services and benefits are covered by the savings; that is, the difference between our adjusted community rate and 95 percent of what medicare calculates it would pay in the fee-for-service system.

Our media campaign in 1980 effectively demonstrated an HMO's ability to attract some 6,000 new enrollees and to attract a representative age and geographic cross section of the senior citizen population. Medicare beneficiaries were motivated to enroll by the premium savings and the additional benefits.

The annual cancellation rate of the health plan members in this experiment approximated 3 percent, which indicates a high level of acceptance.

Since we have demonstrated the feasibility of attracting such members, we feel it is important for the Federal Government to adopt policies that will facilitate the enrollment of medicare eligibles in group practice, prepayment plans, and other HMO's. And we offer these suggestions in that regard.

First, that the amended section 1876 of the Social Security Act [TEFRA amendments] be implemented. These allow payment of capitation payment amounts to HMO's and competitive medical plans. The enabling legislation for this was passed in mid-1982. Proposed regulations to implement this section were published by HCFA only 7 weeks ago.

Second, eliminate the current requirement that two new medicare members have to be enrolled by an HMO for each existing medicare member converted to a risk contract. This is unfair to existing medicare HMO members, deprives them of additional benefits, provides no financial incentive to attract new enrollees, and creates two classes of medicare enrollees.

Third, work to improve the adjusted average per capita cost methodology.

Fourth, assure stability in the HMO payment methodology.

Fifth, promote the HMO option to medicare beneficiaries.

Sixth, encourage demonstration to test new concepts in financing as well as organizational and benefit concepts for the Medicare Program.

At present HCFA invests for research and demonstration only about 5 cents of every $100 of medicare expenditures. And recently demonstrations have been significantly threatened by the actions of the executive branch. For example, our proposed medicare plus II experiment. Medicare plus is now considered a first-generation experiment and demonstration. The lessons learned will be most useful to other HMO's.

However, we also learned about the need to extend long-term care and in-home support options. To us it is timely and important to test whether it is possible to integrate acute and long-term care and to integrate private premium revenue and medicare revenue in a manner that would produce better care for medicare beneficiaries and ultimately save money for the Medicare Program. This led to the development of a proposal for a social/HMO demonstration which has been submitted to HCFA. The idea is to increase private premiums by using insurance principles for long-term care and offering support services to avoid nursing home admissions.

The recently passed deficit reduction legislation contained an amendment proposed by the Senate Resource Committee that directs the Secretary of HHS to approve the waivers for this project. We are looking forward to beginning medicare plus II shortly, and we believe that similar demonstration projects need to be encouraged rather than discouraged. Serving the senior citizens of our community is one of the most satisfying aspects of our program. We sincerely apprecite the opportunity to share with your Committee our experiences with medicare and our thoughts about legislation affecting the future of prospective payment for medicare providers. Thank you.

Senator EVANS. Thank you very much.

[The prepared statement of Mr. Wagster follows:]

PREPARED STATEMENT OF DANIEL O. WAGSTER

Good morning Senator Evans and members of the Senate Committee on Aging. My name is Daniel O. Wagster, senior vice president, Oregon regional manager and a member of the boards of directors of Kaiser Foundation Health Plan and Kaiser Foundation Hospitals.

It's a pleasure to appear before you today to discuss the Medicare Plus Project and the Kaiser Permanente Medical Care Program in Oregon and Washington and the successor demonstration project on which we are about to embark, known nationally as the Social/Health Maintenance Organization demonstration and known in Oregon as Medicare Plus II. First, however, I'd like to establish the setting for the two projects and the delivery of comprehensive medical services by the Kaiser-Permanente Medical Care Program to residents of Oregon and southwest Washington.

The Kaiser-Permanente Medical Care Program has 40 years' experience in the health care field in Oregon and southwest Washington. Beginning during World War II, it provided medical care to Kaiser shipyard employees and their families in the Vancouver, WA and Portland, OR areas. After the war, the health plan was opened to public subscription and offered to employer and union trust groups and individuals. Today, Kaiser-Permanente, a federally qualified health maintenance organization [HMO], is the Nation's largest group practice prepayment plan. Comprehensive medical and hospital services are provided to 4.5 million voluntarily enrolled members in the nine Kaiser-Permanente regions—northern and southern California, Colorado, Hawaii, Ohio, Texas, Connecticut, the Washington, D.C., area, and Oregon/Washington (known as the Oregon Region). Efforts are underway to expand to two new areas: North Carolina and Georgia.

The Kaiser-Permanente Medical Care Program in the Oregon region now serves nearly 270,000 members, of whom approximately 26,000 are age 65 and over. In addition to comprehensive physician and hospital services, dental benefits are provided to about 58,000 members in Oregon and Washington. Physician services are provided by nearly 300 physicians affiliated with Northwest Permanente, P.C. and dental care is provided by the 38 dentists of Permanente Dental Associates. Fifteen facilities are involved in the provision of health care to members in Oregon and southwest Washington.

Our facilities include two hospitals—Kaiser Sunnyside Medical Center and Bess Kaiser Medical Center. Members receive ambulatory services at 10 medical office facilities, including a facility in Vancouver, WA. This fall, we plan to open our newest medical office in the Longview/Kelso area thus enabling residents in that area of southwest Washington to enroll in Kaiser-Permanente.

The program also has a mental health center, an alcohol treatment program, a cancer counseling center, a community medicine department, a home health agency, a hospice program and a nationally recognized health services research center.

It is in this background the Oregon Region and its health services research center have established a long tradition of conducting medical care experiments affecting the organization of medical care within Kaiser-Permanente and other HMO's and providing data to illuminate national public policy debates in health care.

A basic component of current national health policy is to encourage the development and growth of HMO's as a cost-effective alternative to the fee-for-service health care delivery system. The cost effectiveness of HMO's has been demonstrated by a number of studies. For example, the June 7, 1984 issue of the New England Journal of Medicine reports a study by a Rand Corp. research team which substantiates the cost-effectiveness of group practice prepayment HMO's such as Kaiser-Permanente. The 10-year, $80 million study included a component conducted in cooperation with Group Health Cooperative of Puget Sound which assessed HMO medical care. This component found that costs of medical and hospital care in a group practice prepayment plan were 25 percent less than the costs of care from fee-for-service physicians.

The study team attributed the cost differential primarily to the lower rate of hospital admissions for people enrolled in the group practice prepayment plan, which was "about 40 percent less than in the fee-for-service group." The researchers concluded their study "suggests that the style of medicine at prepaid group practices is markedly less hospital-intensive and, consequently, less expensive."

The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) authorized HMO programs for medicare prospective risk contracts in recognition of the value of developing provisions that will encourage HMO's to increase their participation in the medicare program. There were several issues that had to be addressed, however, before the passage of that legislation.

The interest of group practice HMO's in substantially increasing their participation in medicare depends upon the extent to which those programs are

changed to include HMO provisions that are consistent with the way successfully organized systems of care operate.

An awareness of the extent to which reimbursement formulas can affect costs and the failure of retrospective cost reimbursement to embody cost consciousness in the delivery of services led to the advocacy of prospective reimbursement.

The critical factor in increasing the number of medicare beneficiaries enrolled in HMO's is to provide sufficient incentive for them to enroll in an HMO when to do so means that they have to accept less freedom of choice of physicians and hospitals than they may generally have under medicare. This can be accomplished by paying HMO's a meaningful portion of the savings resulting from their efficiency which may be passed on to their medicare members in the form of added benefits or lower rates or both. However, this requires paying HMO's more than their adjusted community rate for providing medicare covered services but will result in HMO members receiving greater benefits than other medicare beneficiaries. Although this is contrary to the basic manner in which medicare operates, it is essential if HMO participation in that program is to be increased. Incentives for enrollment in cost-effective systems are a basic requirement for significant delivery system reform.

Besides attracting more members, it is economically sound to reward prudent purchasers of health care services. As it now stands, the medicare program interferes in the efficient economic performance of the health sector. By eliminating, or practically eliminating the participation in the payment of the health insurance premium, the participant can no longer benefit financially from his choice to purchase less expensive medical services.

There are a number of methods and formulas for paying HMO's, but there are two principles that are essential for the active participation of HMO's on a risk basis. They are:

(1) The rate should be determined prospectively and should be on a per capita basis. Both the HMO and the medicare programs should know what the rate will be in advance. This will allow each to plan and budget accordingly.

(2) The rate should include the savings which an HMO creates through its operational efficiencies when compared with non-HMO costs in the area. The savings should be used to provide added benefits or lower rates to encourage persons to join the HMO.

The Kaiser-Permanente Medical Care Program, which is the largest group practice prepayment plan in the United States, has had extensive experience in serving as a provider of care to medicare and medicaid beneficiaries and in participating in the development of Federal and State statutes, regulations, and policies concerning HMO's.

From the original beginning of the medicare program, Kaiser-Permanente received payment for part A (hospitalization) services provided to its medicare members on the basis of the cost of such services determined retrospectively using standard medicare rules. Part B payments are based on retrospective cost determination in accordance with the group practice prepayment plan provision of the medicare act. Medicare members are enrolled in a supplemental plan which covers the deductible and coinsurance amounts not covered by medicare and provides selected optional services such as preventive health services and outpatient drugs, which medicare does not cover. Thus, medicare does not pay the Program a prospectively determined rate, which is the usual way in which the Program receives payment; nor does the Program have any contracts under section 1876 of the act (the medicare HMO provision).

Consequently, the program had not made substantial efforts to enroll medicare members who are not already members for the following reasons:

(1) The benefit or rate incentives for non-Program members to join the Health Plan are inadequate or uncertain.

(2) The existing payment provisions (sections 1815, 1833, and 1876) are inconsistent with the Program's basic method of operation because they involve retroactive determination of the amount of payment, an irrational method for Program planning and operation, instead of paying on a periodic rate basis.

(3) There was significant concern that the "lock-in" requirements of section 1876 would be difficult, if not impossible, to impose upon the Program's existing medicare members.

However, in 1978 the Health Care Financing Administration (HCFA) awarded seven medicare demonstration contracts to test the feasibility of increasing enrollment of medicare beneficiaries in HMO's. One of the contractors was the Kaiser-Permanente Health Services Research Center in Portland, OR.

The first objective of the demonstration in Portland (called Medicare Plus) was to design a prospective payment system which provided sufficient incentives to medicare beneficiaries to join the HMO, which would cost the medicare program less than services purchased in the community from fee-for-service providers, and which would provide appropriate payment to the HMO.

Under this demonstration, HCFA paid the Kaiser-Permanente Care Program at the beginning of each month a set amount for each Medicare Plus member. The payment includes Kaiser-Permanente's adjusted community rate for medicare covered services (ACR). The ACR covers all members A and B services and is adjusted to reflect differences in benefits, utilization rates, and the differential time and complexity of providing services for medicare enrollees compared to other enrollees of the health plan. This ACR is all that Kaiser-Permanente receives for medicare covered services.

In addition to the ACR, the monthly payment covers a contribution toward the cost of standard medicare supplemental benefits, plus payment for special new member services. These additional benefits and services are provided from the "savings"—the difference between the ACR and 95 percent of what medicare calculates it would pay for these beneficiaries in the fee-for-service system (the average adjusted per capita cost or AAPCC). Each year a monthly rate is calculated for the coming year.

The Medicare Plus Program began with a special media campaign designed to ensure that all medicare beneficiaries in the Portland-Vancouver area were invited to join the project. Television and newspaper announcements were supplemented with regular contact with public and private agencies serving the low-income and the elderly. A total of 15,000 beneficiaries request information packets on Medicare Plus. The Medicare Plus Project enrolled nearly 6,000 new medicare beneficiaries and approximately 2,000 conversion members into the demonstration.

The marketing campaign was effective in notifying eligible participants and in attracting people likely to enroll. It also demonstrated the ability to attract a representative age and geographic cross-section of the senior citizen population. The enrollment of 6,000 new medicare members into Kaiser-Permanente raised the percentage of over 65 members from 6.85 percent in 1979 to 9.4 percent in 1981 and about 10 percent in 1984. As a result the KPMCP now serves more than 18 percent of all medicare beneficiaries in the Portland SMSA, with a total of 26,000 medicare beneficiaries served under risk or cost contracts. The health plan's overall market penetration for 1981 was 19 percent.

The Medicare Plus Project in Portland and successful programs in Massachusetts and Minnesota demonstrated that it is possible to design a workable prospective payment system and that medicare beneficiaries can be motivated to join an HMO by offering them a premium savings or more benefits than they usually have available. Although outpatient utilization was somewhat higher than predicted, inpatient utilization was near predictions for this population. An annual cancellation rate of only 3 percent indicates a high level of member acceptance.

These findings indicate the feasibility of public policy encouraging enrollment in HMO's by increasing their participation in the medicare program. The findings also demonstrated that increasing medicare enrollment in HMO's has a potential to help contain medicare costs and decrease hospital utilization for an increasing aged population in the United States.

The provisions necessary for encouraging more HMO's to compete for medicare patients are now enacted into law in the 1982 TEFRA. However, the proposed regulations for this program were just released. Kaiser-Permanente has prepared comments on the regulations, which appear generally to allow a program very simlar to the Medicare Plus demonstration.

We feel that it is important for the Federal Government to adopt policies that will facilitate the enrollment of medicare eligible in group practice prepayment plans and other HMO's. Action that could be taken by the Federal Government to facilitate this would include:

1. IMPLEMENT AMENDED SECTION 1876 OF THE SOCIAL SECURITY ACT

This amended section (TEFRA amendments) allows HMO's and competitive medical plans to enroll medicare beneficiaries and be paid a prepaid capitation amount. The difference between the payment and the HMO's adjusted community rate is to be provided as additional benefits to the medicare enrollee, thereby providing a financial incentive to the beneficiary to join the HMO. Enabling legislation for this program was passed in mid-1982. Proposed regulations to

implement it were published by HCFA on May 25, 1984. It should finalize those regulations in an expeditious manner, so that program implementation can begin.

2. ELIMINATE THE CURRENT REQUIREMENT THAT TWO NEW MEDICARE MEMBERS HAVE TO BE ENROLLED FOR EACH EXISTING MEDICARE MEMBER CONVERTED TO A RISK CONTRACT

This provision is unfair to existing medicare HMO members, since it deprives them of additional benefits available to new medicare HMO members. It provides no financial incentives for them to get their care from the HMO. It creates administrative problems for the HMO as well as confusion and misunderstanding among the medicare beneficiaries.

3. WORK TO IMPROVE THE ADJUSTED AVERAGE PER CAPITA COST (AAPCC) METHODOLOGY

The AAPCC represents the fee-for-service equivalent of providing care to the non-HMO enrolled medicare beneficiaries in a geographic area. While this methodology appears adequate to begin the program, it is important that HCFA work to improve this methodology. To accomplish this, efforts should be undertaken to advance the "state of the art" so that an HMO and the Federal Government will have assurances that participating in this program will provide fair reimbursement. This should increase HMO participation and assure that the member is properly rewarded for selecting an HMO.

4. ASSURE STABILITY IN THE HMO PAYMENT METHODOLOGY

There is a need to assure that the "rules of the game" are stable over time. This includes both payment and operational requirements. This will help stimulate active HMO participation and prevent fluctuating premiums or benefit levels for medicare enrollees.

5. PROMOTE THE HMO OPTION WITH MEDICARE BENEFICIARIES

The Health Care Financing Administration (HCFA) should fully inform medicare beneficiaries of the HMO option and the benefits and restrictions associated with selecting it. Consideration should also be given by HCFA to the development and distribution of enrollment literature and cost information, so that a beneficiary has the opportunity to compare the benefits and costs of each of the plans with risk contracts in the service area. We recommend that prior to becoming medicare eligible, each prospective beneficiary be informed of the service options available in the geographic area and requested to make a choice among them.

6. ENCOURAGE DEMONSTRATIONS TO TEST NEW CONCEPTS FOR THE MEDICARE PROGRAM

The Federal Government should encourage demonstrations that test new financing, organizational and benefit concepts for the medicare program. Currently less than $30 million are invested by HCFA in medicare research and demonstration, an amount that equals about five cents for every $100 of medicare expenditures. And recently demonstrations have been significantly threatened by the actions of the executive branch.

Medicare Plus is now considered a "first generation" demonstration, because a considerable portion of the planning period was devoted to developing the rate methodology and dealing with medicare waivers and other demonstration requirements. While these activities will no longer be necessary under the new HMO medicare statute, the lessons learned from Medicare Plus will be most useful to other HMO's enrolling medicare beneficiaries.

The lessons learned as a result of Medicare Plus also pointed to the need to extend long-term care and in-home support options available for medicare beneficiaries under a prospective capitation system. What we perceived was required was an opportunity to test whether it was possible to integrate acute and long-term care, and to integrate private premium revenue and medicare revenue—in a manner that would produce better medical care for medicare beneficiaries and ultimately save money for both medicare and medicaid.

However, Kaiser-Permanente (and all other HMO's) know very little about the organization and financing of long-term care. Further, since the medical care marketplace has become so competitive and cost containment oriented, it is very

difficult to interest the managers of medical care programs in engaging in new, risky experiments. However, findings from experiments in long-term care indicated that it might be possible to develop HMO approaches that would utilize insurance principles to increase the proportion of private premium funds that could be spent on long-term care.

When the health services research center was encouraged by HCFA to cooperate with Brandeis University in developing a proposal for a social/HMO demonstration, there were two elements of the proposed demonstration that seemed to increase its potential for successful implementation: A 100 percent AAPCC payment mechanism and an approach for sharing risk between HCFA and the HMO in the early phases of the demonstration. A payment formula that is based on 100 percent of the AAPCC could produce enough "savings" to allow a premium in the marketplace with a reasonable potential for attracting a relatively balanced population of well and frail medicare beneficiaries.

An appropriate balance of healthy and frail beneficiaries is necessary in order to assess the impact of the new services on the cost of the acute services generally provided in HMO risk programs. Because of the extra 5 percent (100 percent of the AAPCC rather than the 95 percent in the original Medicare Plus demonstration), it may be possible to design a feasible benefit package integrating long-term care into a risk program. This should encourage relatively healthy beneficiaries to invest private premium dollars, thereby spreading the cost of long-term care over the total population using insurance principles. The successful application of this approach can reduce the dependence upon state and federal funds for financing the provision of long-term care services.

Kaiser-Permanente developed a proposal that would enroll 4,000 aged medicare beneficiaries in its Medicare Plus II (social/HMO) demonstration from Multnomah County, OR. Of these, 2,000 will be converted from Kaiser Foundation Health Plan existing medicare membership; the balance will be 500 medicare/medicaid recipients and 1,500 regular medicare recipients from the community who now receive their care through fee-for-service sources. The proposal, which was approved by HCFA, has been delayed since January in a disagreement between the Office of Management and Budget and HCFA over the use of waiver authority to experiment in medicare and medicaid. The recently passed deficit reduction legislation contained an amendment proposed by the Senate Finance Committee that directs the Secretary of Health and Human Services to approve the waivers for this project. We are looking forward to beginning this project shortly and we believe that similar demonstration projects need to be encouraged rather than discouraged.

Serving the senior citizens of our community is one of the most satisfying aspects of our program and we are very pleased to play a role in pioneering projects that successfully demonstrate it is possible to provide quality medical care at a saving both to medicare beneficiaries and to the medicare program.

We sincerely appreciate the opportunity to share with this committee our experience with Medicare Plus, and our thoughts about legislation affecting the future of prospective payment for medicare providers.

I have with me copies of this testimony, along with copies of the Rand study referred to and information about Medicare Plus and the social/health maintenance organization experiment. Thank you.

Senator EVANS. The fourth witness is John Haugan from the John Tenten retirement group in Spokane. He has been involved with aging issues for over 30 years and served as a delegate to the White House Conference on Aging and has pioneered some very interesting work in wholistic health care with senior citizens, with a main emphasis on keeping the elderly out of nursing homes and other institutional arrangements. We will hear about Mr. Haugan's work with the Lilac Plaza and Holman Gardens retirement homes in Spokane. I understand you have similar projects pending in other communities in the Northwest. I am sure the experience of this project will provide us a unique perspective, one which we hope will be another valuable alternative to the challenge we have in front of us. Mr. Haugan.

STATEMENT OF JOHN F. HAUGAN, ADMINISTRATOR, LILAC PLAZA, SPOKANE, WA

Mr. HAUGAN. Thank you. I am John Haugan. I am the administrator for 12 years of the 175-unit, 13-story, low- and moderate-income housing project called Lilac Plaza. And I am also the administrator of Holman Gardens, a brandnew, 96-unit, privately financed housing project. I served as a founding director for a senior citizens center in Missoula, MT. And Senator Evans mentioned about being a delegate. I was the planning director for the State of Montana, with the responsibility of coordinating the White House Conference on Aging, the second White House conference. It was composed of determining needs, there were forums—those of you who are old enough to remember the second one. The first 3 months were forums to discuss needs, and then task forces were set up to discuss, "How can you meet the needs on a local, State, and national level?"

There were 195 recommendations that came out of it. And then when I went to Lilac Plaza, I had a guide book on how to run a retirement home. And, so, there are several things that I think that are necessary. Why is it important that we have a Lilac Plaza and Holman Gardens? There needs to be a continuum from your own home to a nursing home. There has to be an in-between stage. And that is where we come in. I feel it is an absolute necessity that we have an in-between.

Catholic Charities made a study of nursing homes in the Spokane area, and there were 33 percent of the people who needn't have been in a nursing home if there was just a little care available. And that is where we have tried to fill the need. I learned about the needs and how to meet the needs.

The first thing that is absolutely necessary is the meal program. If a person does not eat properly, a tea-and-toast diet means senility or, in the medical term, dementia. If you do not get enough vitamin B–12 and enough food, you are going to wind up senile, and you are going to wind up in a nursing home.

If a person does not eat enough—if someone says, "It does not make any difference whether I eat or not," it means a difference to all of us as taxpayers because we are going to foot the bill to take care of a person in an institution.

The second thing that is absouutely necessary is the preventative and early detection health program. I ran Lilac Plaza for a couple years. But one of the recommendations of the White House conference was prevention and early detection. So, I was finally in a position to hire a nurse from the Visiting Nurses Association to come in, and we were able to experiment in keeping people well.

The month before we had our first nurse, we had two people go to the hospital, one with a broken blood vessel, the other with a broken blood vessel in their head, which meant a stroke. After we got the nurse, the people who had high blood pressure were sent to doctors and kept under medication. That is the sensible way to do it. A person with high blood pressure is a walking time bomb. And if he does not know it is ready to go off any time, then we take care of them and we have all kinds of services to take care of them after the fact, whereas a preventative program could prevent it.

A third thing is the exercise program. And this is why in designing Holman Gardens we have a track, an indoor track. We have an exercise room. We have a swimming pool, an indoor swimming pool and a Jacuzzi. For people with arthritis, it is excellent.

And the fourth is a full range of social programs to meet every need, including the need to be needed. Senior citizens should not be put on the shelf. And, so, I am constantly looking for opportunities where people can use their talents and abilities in a constructive way.

Why Holman Gardens? Why Lilac Plaza? There are some people who need full nursing care. And we are grateful for that. But my job is to keep people out of nursing homes. And at Lilac Plaza I made a survey—and it is in my prepared statement—of 210 people. Incidentally, it was not just myself. I had one of the residents and a secretary and myself. Of the 210, I rated them: one, good health; two, some problems; three, lots of problems; four, absolutely would be in a nursing home if we did not have our support services. And there were 33—because we have been there 12½ years now, and some of the people in 12½ years are a little bit more frail.

How can I illustrate it? Oliver was 80 years old when he moved into Lilac Plaza. He was a retired railroad engineer. When he was 85, he had heart failure, which meant that he could not get down to the dining room anymore. I asked a woman by the name of Agnes if she would look after Oliver. I mean, bring a tray up. We had tray service. Then the nurse would check on him a couple times and report to the doctor. And Agnes prepared a breakfast for him too. Oliver lived in that condition until he was 90, when he went to the hospital and had an operation and did not survive. That saved at a least $1,000 a month because Oliver, if he had been any place else, would have had to have been in a nursing home. And that saved $1,000 a month for 5 years. That is the sort of thing I feel is an alternative or a supplement.

There is a couple other things. There is Gwen, who came into Lilac Plaza when she was—we have a 4½ year waiting list—and she was pretty confused. And I thought, "Boy, I made a mistake in having her come in." But she did come in, and after about a month of eating properly, she was back to normal. So, I saw in her the demonstration that a person who is not eating properly—because she is almost blind—had started to become senile, and it was reversed. And that is the wonderful thing about it, that these things can be reversed.

I think that there are many other things that I could tell you about. At Holman Gardens we are just starting out. We are going to have a before and after. We would like to take a health survey before and a health survey after to show that this type of program is really effective and worthwhile.

We have a slogan in the Lord's Prayer: "Thy Kingdom come, Thy Will be done on Earth." That is, "Thy Will be done on Earth at Lilac Plaza and Holman Gardens, just as it is in Heaven." [Laughter.]

So, is is our function to create a bit of Heaven. There are some people in it who create the other way. [Laughter.]

But with that, I will close. Thank you for letting me testify.

Senator EVANS. Thank you very much. It has been a very interesting panel, a variety of alternatives. Let me get back now to some of the questions that have occurred to me in listening to this testimony. But,

first, John Haugan's written testimony will be made part of the record.

[The prepared statement of Mr. Haugan follows:]

PREPARED STATEMENT OF JOHN F. HAUGAN

Lilac Plaza is a 236 rent supplement and section 8 retirement home for low and moderate income people. The new residents must be able to take care of themselves. We have no nursing facility. The board and staff of Lilac Plaza have a goal to be a full program retirement home, with such policies as "meeting every need of every resident" and "to create a bit of Heaven". This fulfills that portion of the Lord's Prayer, "Thy Kingdom come, Thy will be done on Earth (Lilac Plaza) as it is in Heaven."

Because of having been a part of the second White House Conference on Aging, I was aware of the needs of senior citizens and, thus, could have programs and activities which could meet the needs of them. One of the most important is having one meal a day. People who do not eat properly can eventually suffer from dementia because of lack of protein and proper vitamins. (2) A preventive and early detection program is an absolute "must" and should be in every retirement home in the country. Medicare is backward. They wait until a person is sick and then pay to correct the problem. (3) Social programs are necessary. Dr. James Lynch, in his book, "The Broken Heart,' 'states that loneliness is the No. 1 killer in the United States. (4) A spiritual program. This is a very significant part of the life of a retired person. (5) Arts and crafts. It is very important that opportunities be provided to utilize talents and abilities and to alleviate the fear that they will be put on a shelf. (6) Gardening. At least 50 of the 175 families at the Plaza utilize the opportunity of gardening. It is very therapeutic, in addition to helping provide their own food. There are many other programs and activities which are provided, such as a music program, parties, classes, games, etc.

In addition to providing a much higher quality of life with these activities, there is a definite financial factor for justifying such a full program retirement home. Lilac Plaza has been in operation for 12 full years. We have a number of the original residents still living here. For this letter, the secretary, one of our charter residents who helps in the office and I rated each of the residents in the building by "1"—good condition; "2"—some problems; "3"—many problems and "4"—would be in a nursing home if we did not have a meal and nursing program. Of the 210 residents, 33 were in "4" class. It would cost the resident, the family or the State at last $1,000 more per month if these people were in a nursing home. This is $396,000 a year savings. Because most of our residents are low and moderate income, it means the State would pick up the tab between what they have and what it would cost in the nursing home. It is very likely that the other 24 who are in the "3" class would probably be in a nursing home if they had been in another home where there was no meal or nurse to check up on them. This figure would be another $288,000.

In 1978, the State budgeted $177 million per biennium for nusing home care. In 1982, the figure was $344 million or almost doubled in 4 years. There is absolutely no way in which this figure is going to be reduced because almost every patient in the nursing home uses up his or her assets in a short while and becomes a ward of the State.

The goal at Lilac Plaza is "to meet every need of every resident." The following programs, activities and facilities are available to meet those needs:

(1) A meal program. The meal is served at the table, not served cafeteria style. There is a provision for special diets and tray service is available.

(2) A nursing service, with emphasis on prevention and early detection. The nurse monitors blood pressures twice weekly, gives shots under doctors' orders, gives foot care and checks up on medications. She visits the sick in their apartments and reports to the doctor.

(3) A notary public is a free service.

(4) A copy machine is available, at cost.

(5) There is a small change drawer for making change for buses, laundry, etc.

(6) Volunteers in the office make out meal tickets for residents' guests, take care of their dry cleaning and prescriptions delivered from the pharmacy and help residents with any problems they may have.

(7) Coffee, tea, and bouillon are available free from 9 till noon in the lounge to provide a social time for the residents.

(8) Residents may have their own gardens.

(9) Bus service to the door.
(10) Bookmobile serves our residents.
(11) Library available in the building.
(12) Coin-operated laundry.
(13) Co-op grocery store run by residents.
(14) Music program daily with different pianists and song leaders.
(15) Voting precinct in their building. Voter registration cards are filled out for residents to transfer their registration. Candidates are invited to speak to the residents and issues are discussed.
(16) Democracy in action—a residents' council meets weekly with the administrator. They set up committees to handle problems which arise, plan monthly parties and set up twice-yearly pancake breakfasts and bazaars.
(17) Floor monitors check on residents daily.
(18) Vesper services are held each Sunday and Bible studies weekly.
(19) Film programs.
(20) Craft programs.
(21) Classes are avaiable for painting, defensive driving, nutrition and weight control.
(22) Exercise classes and equipment are available.
(23) Service projects, such as making lap robes (over 1,100), quilts for families burned out, etc.
(24) Utilization of church, service and community organizations. The Rotary, Kiwanis and Lions' Clubs have helped with building projects.
(25) Whitworth College and Spokane Falls Community College have been utilized for classes and by providing students on work study and class projects. The students help set up programs and projects.

Senator EVANS. I will question the witnesses in the order people testified. Mrs. Katterhagen, you talked about the necessity for changing rules to come. I guess I have the same question that I had asked earlier: Do you think that this ultimately indicates a need to merge Medicaid and Medicare into a single system for the elderly?

Mrs. KATTERHAGEN. I think it needs to go further than that, Senator. I think the Medicaid and the Medicare Programs deal with the health issues of the individuals. And what we have described to you today shows that people are more than just health issues. There are also social issues, and there is a whole social system under title XX that is being provided to people, but the two are not mixing on a community level. And that is where a huge gap is occurring. So, I would suggest that all three get merged in some fashion and to have the admission requirements valid for all three so that services can be provided to people when the need is there.

Senator EVANS. I suppose the one thing that I am not aware of is whether anyone has done significant research yet on what anticipated costs we might face with a merged system of that nature.

Mrs. KATTERHAGEN. We might reduce costs, Senator, by eliminating some of the bureaucracy, No. 1. No. 2, what I am not suggesting is that you open the admission criteria. What I am suggesting is that you just combine the systems so that we end the duplication and seal up the gaps because what is happening—for instance, the lady I defined will end up back in a nursing home because of the gaps between the health and the social systems.

Senator EVANS. You mentioned the intermediaries and some of the problems which come from those. Of course, the development of that concept came before I was in Congress, but I would be willing to bet what gave rise to all of this. It is so typical of what happens in a legislative body that when a problem develops a program is started. Then the stories start coming back of inappropriate or fraudulent use, and Congress decides they have got to get a handle on that, so we set up a

system of controls and direction. And I suspect that is precisely how we got to this particular juncture.

Do you have any suggestions as to how we can avoid this without getting into the bureaucratic maze that we appear to have gotten into?

Mrs. KATTERHAGEN. In conversations with the intermediary it appears to us today that they are spending more time controlling and a lot less time allowing services. I myself go to the intermediary approximately once or twice a week pleading individual cases with them, as I described the 72-year-old man. They are telling me today his service will be denied. I think that there are not that many people out there who are providing fraudulent and overutilization of services. And I think that the emphasis on fraud and abuse is inappropriate.

Senator EVANS. As I remember from your testimony today, that particular case was one in which they were denying service because the recipient was no longer making progress or was stable.

Mrs. KATTERHAGEN. They were denying the service that was provided during the time that he—from the time he was paralyzed to today. And they are calling that not progressing.

Senator EVANS. It seems to me with that kind of description, it is an erroneous idea of what is happening in the real world of health care delivery. When you get to the stable position and then the denial of service when there is no longer progress being made, is that more a regulatory or a statutory requirement?

Mrs. KATTERHAGEN. I believe it is regulatory. Most agencies, Senator, when a patient arrives in a stable position, discharge the patient. This particular patient is not stable. He is still learning to walk more and to walk better. So, he is not considered stable at this time.

Senator EVANS. I would guess, especially for the elderly, there will be many cases where someone reaches stability but cannot be discharged from a particular service. There may be a different level of service required on a continuing basis, but in a good many cases you cannot simply be discharged from all services.

Mrs. KATTERHAGEN. That is true. Many times an individual when they arrive at that point, is then referred to the COPES or the Chore Program because the Medicare Program requires an individual to need skilled care. And usually when you are stable, your requirements for skilled care are not there. So, you are referred to the COPES and the Chore Program, Chore which is the social service system but also provides care for individuals. One of the problems with that is that the elderly statistically have at least two to three disease processes going on, as you defined. So, an individual may be stable today and completely and totally unstable tomorrow. So, having a social service then with a provider who knows nothing of the healthcare system can at times increase the problems.

Senator EVANS. You made an interesting comment that Pierce County seems to have more nursing home care than other areas. Would you care to speculate on why?

Mrs. KATTERHAGEN. No.

Senator EVANS. Perhaps you know why.

Mrs. KATTERHAGEN. In my view, it comes from a couple of institutional biases on the part of the case worker, on the part of the discharge planner in the hospitals and also on physicians. We are working to change that, but it is going to be a long slow process.

Senator EVANS. On something like that, I am not certain whether there is anything that can be done either by statute or through regulation that would truly resolve that problem. Is it not more a question of education?

Mrs. KATTERHAGEN. Not always, Senator. If there were incentives placed upon discharge planners to put a patient in the most appropriate setting rather than to push the case on, you could have a better incentive program.

Senator EVANS. What kind of incentives would you suggest? What would work best?

Mrs. KATTERHAGEN. I think that, as I went back to the recommendations I made, the vertical integration of the program with the incentives to provide care at the most appropriate level, which is not being done today. In my view, people are being placed in the nursing homes and then into the Medicaid Program when they spend down their money. If we had used the incentive in the first place of providing services in the home, we would not arrive at the high use of medicaid. So, I think that the incentive program has to be developed toward the provider.

Senator EVANS. Vertical integration of that type would be an integration of systems partially governmental, partially private, partially community based. How would you suggest doing that? What is an adequate way to get that kind of vertical integration? I guess what it really comes down to is knowledge. A recipient needs knowledge of the variety of facilities or care available and then some way to ensure that a person is given the appropriate level of care.

Mrs. KATTERHAGEN. Let me point out that our social workers that work for my organization have a notebook this thick [indicating 4 inches] of just the social services available to the elderly in Pierce County. There is no way that an individual can understand all that, even the individuals that are required to do it.

So, I think that, to go on, a vertical integration could be done by contracts. It could be done through a social HMO that would combine with a health care organization. But I think you would have to do it on a capitated basis to provide the right incentives. I see occurring today hospitals unfortunately going into home health more and more, but going into community-based services in order to utilize more appropriate funding sources. So, I think we are heading in that direction, but we may not be going quite fast enough.

Senator EVANS. Do you have any suggestions either now or that you would care to submit later that could help us speed the process?

Mrs. KATTERHAGEN. OK. Thank you.

Senator EVANS. If you could, I think it would be helpful, because I think you are on the track that we need to try to follow. The question is how rapidly we can get there. You mentioned in your testimony also the failure or lack of participation in the hospice program. Do you have particular suggestions as to what should be done to encourage broader participation? What needs to be done?

Mrs. KATTERHAGEN. I have a lot of suggestions, Senator. I am the hospice representative to the National Association for Home Care, and we have been working for some time to change some of the regulations, both statutory and regulatory.

First of all, the $6,500 that Congress put as a cap for hospice payment is appropriate. But when it got to the regulatory side, the individual daily rates are so low, that we will go broke in trying to provide it. And I personally do not believe that it is the purpose of a community-based provider to go broke for the Federal Government.

Senator EVANS. We are doing a pretty good job of that ourselves. [Laughter.]

Mrs. KATTERHAGEN. Another problem that I hear across the country quite frequently is the inability of a provider to obtain the contracts that I mentioned. The legislation required that a hospice provider have management and fiscal control of the inpatient services that were provided. Most hospices are developed within communities working together like a home health agency working with a hospital. It is the rare hospital that will give a home health agency managerial fiscal control over a piece of their hospital. And that is what the legislation required. And very many programs are unable to accomplish this without becoming a subsidiary of the hospital, of which many do not like that either.

Another regulatory occurrence that is happening, the regulations required that on admission to the hospice program the patient sign a release allowing the intermediary to come to the patient's home and interview the patient. The psychology of that is just mind boggling. You have a dying patient that is going to be interviewed by an individual that may or may not be a health care provider and may not know anything about them. It just blows your mind, in my view. And the whole regulation, it just goes on. And I will be happy to provide a very long list for you.

Senator EVANS. All right, that would be very helpful, because that is what we are trying to get at, doing things that we can do to help make the process work better.

Mrs. KATTERHAGEN. I will ask the State organization, of which I am vice president, to help me on that.

Senator EVANS. All right.

Mrs. KATTERHAGEN. Thank you.

[Subsequent to the hearing, Mrs. Katterhagen submitted the following material:]

HOSPICE OF TACOMA,
Tacoma, WA, July 13, 1984.

Hon. DANIEL J. EVANS,
Special Committee on Aging,
Washington, DC.

DEAR SENATOR EVANS: I appreciated the opportunity of testifying at your hearing in Seattle, on the long-term needs of the elderly. During the question period, we were discussing the new hospice benefit, and you asked that I send you a list of concerns about it.

Attached is a paper describing those concerns, developed by the Washington State Hospice Organization [WSHO]. This paper was sent to all members of the Washington congressional delegation.

We look forward to working with you on this issue. We feel strongly that modifications must be made to both the statute and the regulations in order to assure access to hospice for the elderly.

Thank you for your help in this matter.

Sincerely,

ANNE KIRCHNER KATTERHAGEN,
Executive Director.

Enclosure.

CONCERNS REGARDING MEDICARE HOSPICE BENEFIT

ADMINISTRATIVE

1. The law requires that the hospice provide and be responsible for essentially all aspects of the patient's care: Care received at home, in an inpatient setting, all pharmaceuticals and supplies, all outpatient treatments, all medical equipment used. This means that, for all practical purposes, a hospice must operate like a health maintenance organization. There are multiple problems with this.

The vast majority of hospices are small, community-based organizations which are not prepared to assume the administrative burdens and costs associated with such an operation. Though many small hospices are being acquired by large organizations, the burdens still appear excessive, especially in view of the small number of patients who are likely to make use of this program.

2. The mode of operation required by the law is in direct conflict with the practice patterns which currently exist in most Washington communities. Few hospices, especially on the west coast, are so centralized as to be able to manage the medicare program. Most hospices work with a variety of different organizations and individuals to achieve their ends. For example, Hospice of Seattle, a home care hospice, serves patients who would use, if necessary, any one of 17 area hospitals. The law also requires that the hospice be "professionally, managerially responsible" for all aspects of care, including inpatient care. This means that the hospital must allow the hospice home care provider to dictate what goes on during the time the patient is hospitalized. Few hospitals, let alone the patients' personal physicians who historically have been the source of "orders" for patient care, are willing to give up control of patient care. The legal ramifications of such an arrangement are unknown and for this and other reasons the American Hospital Association has recommended to its members that they not participate. Further, the administrative burdens of managing the care for a handful of patients from outside the hospital in 17 different sites, are staggering.

Suggestion.—Modify the statute to allow contracts for inpatient services without the administrative control requirement.

3. The 80/20 rule. The statute states that no more than 20 percent of all patient days can be institutional days. All hospice providers recognize and agree that the goal is to keep the patient home if at all possible. However, no program can predict what the absolute number of patient days, in home and in institution, will be. Further, this is not a per patient ceiling on the number of days; it is a per agency ceiling. So literally, every day of the year, the hospice must compute how many days of inpatient care they have available to "spend" on their current patients. This is a management and ethical nightmare. What does the program do with a patient who needs to be in the hospital and they have no inpatient days left? The program must make a choice between taking the financial loss of paying for the hospital care or deny the patient needed care.

Suggestion.—Change to 60/40.

4. Patient election of the benefit. In order to be on the medicare hospice benefit, the patient must "elect" this program and waive their rights to their traditional medicare coverage. This will discourage many people from using the coverage. It requires the person to psychologically acknowledge that they will soon die. This is simply not compatible with most peoples' attitudes at this time. Patients still hope, they still want access to treatment if something becomes available, they still need to be allowed to cope with their illness in their own way, including avoidance of the subject altogether. Though the patient can revoke the benefit, that really does not solve the problem. The stress of such decisions in and out of this program is a burden these people don't need.

FINANCIAL

Hospice care has never been delivered in precisely the manner described in the hospice law. Therefore the data which would tell us the cost of this care is simply not available. The Health Care Financing Administration [HCFA] does not know it, the HCPA hospice demonstration project does not provide it, and the hospices don't know it. Therefore we have no basis upon which to evaluate the adequacy of the rates. *Yet* the hospice must be financially responsible for everything the patient needs. We cannot calculate the actual potential financial liability. We do know that many hospitals in this area will not contract with

the hospices for this care because the general inpatient day rate of $271 is too low.

Suggestion.—Require HCFA to develop more appropriate levels of reimbursement and NOT to exceed $6,500 per patient.

ETHICAL

Ethical concerns exist in two primary areas. First, day-to-day management of patient care will be ethically perilous because of the 80/20 split, financial constraints, and informed consent requirements. However there are other ethical concerns that are far reaching for our society. The public policy implications in the medicare hospice law is that if you are dying, you are not worth expenditure of as much money as others and you may not have access to certain things. The hospice movement has stood for something quite different. That is that the dying person does still matter, and that society does still care, and that the dying will not be abandoned.

Though all health care providers are acutely aware of the scarce resource problem, we do not feel that such a policy as this should be entered into accidentally—as occurred with the passage of this law.

A few of the WSHO's members are planning to try to make this program work. They however concur that this program is risky in many ways and realize that they may not succeed.

Medicare beneficiaries need access to hospice care, hospices need medicare reimbursement to survive. Unfortunately, this program is unlikely to move us much closer to either of those ends.

Senator EVANS. Ms. Wintringham, the suggestion that medicare, medicaid, and other public funds supporting care of seniors must be integrated under a coordinated set of rules. I guess this proposal gives rise to the same question I have asked other witnesses—whether you think medicare and medicaid ultimately need to be merged or whether it is just a merging of some of the regulations and rules that apply to the two.

Ms. WINTRINGHAM. The most important parts clearly are the merging of the regulatory and financing aspects. And as Mrs. Katterhagen pointed out, it is not just medicare and medicaid. There are other public sources of funds that are providing or covering the care of seniors. When we speak of medicaid, we are not referring to all of medicaid. I do not believe the intent of medicaid was to care for an elder population. However, in the State of Washington, much like the rest of the country, 40 percent of medicaid funds are now supporting care of individuals in nursing homes. And 40 percent of the people in nursing homes were not on medicaid before they went into the nursing home, but have spent their assets trying to remain in the facility.

So, I think what is most important to us is that the regulations and the definitions of the programs that care for our seniors be integrated. Whether it is one program or just an integration of the rules is less important.

Senator EVANS. You also suggested that incentives to encourage efficiencies in the fee-for-service community should not undermine the HMO's incentives. I am not sure I totally understand that. You might expand on that a bit.

Ms. WINTRINGHAM. In my written testimony I describe in somewhat greater detail a number of examples of regulatory and statutory provisions that were passed not to address health maintenance organizations, but to try to promote some of the incentives we have all been referring to this morning into the fee-for-service practice of medicine. Unfortunately, when they are written—much as when medicare itself

was written—the focus is on the fee-for-service practice of medicine. And I think frequently the drafters forget that some of those regulations also affect health maintenance organizations.

There are a number of examples where the indirect and unintended effect hurts the health maintenance organizations even more adversely than the rest of the community. One of the examples I cited, for example, is the release of proprietary information through the intermediaries, and you referred to that earlier.

The decision was made to involve intermediaries in a greater capacity through contracts from the Federal Government. Most providers are now able to obtain what many consider proprietary information about the competitors in the community. All home health agencies, for example, are now able to obtain a great deal of information about the other home health agencies in the community. But at least in that sector there is a fair sharing and an equal sharing of information on all providers. When the delegation was applied to hospitals, hospital-based health maintenance organizations such as the cooperative was forced to provide marketing information, enrollment forecast, rating information, and patterns and practices of use to our intermediary.

Our competitor is not a hospital or a home health agency for whom we could receive information. Our competitor on the insurance side is Blue Cross or Aetna or some other insurer, and those are the intermediaries. So, here is just one example where the HMO is disadvantaged. We release our information to our competitors. We are not in a position to receive comparable information on them. And they are the ones who are making the decisions about whether our services should be covered or not.

Again, in our written testimony there are a number of other examples like that. And in most cases I think it is merely an unintentional outcome, but with serious implications.

Senator EVANS. To correct that, which way would you go? Would you require that information be shared from those other suppliers, or that the information not be required to the extent that it is from the HMO's?

Ms. WINTRINGHAM. In that particular circumstance we had submitted a number of suggestions on how that problem might be addressed. Unfortunately, there is not similar information on our competitors. They are not providers of health care. They are insurers. So, there is no information on how the care for Blue Cross's patients—because they do not have patients—is provided.

What was suggested as an alternative is that the information should either be protected from the Freedom of Information Act or that one intermediary who is not the traditional insurer and not a competitor, should be designated to review HMO's. There probably should be an intermediary for all health maintenance organizations, who will become more adept at understanding the way health maintenance organizations operate and the way that very different rules apply to those plans. They would be much more skilled in reviewing claims; they would be much more skilled in reviewing the practice patterns and probably could do a better job for the Federal Government.

Senator EVANS. What has been your experience with the addition of the new medicare beneficiaries to your health planning? You have had a number of new people come aboard who are eligible and who become

eligible for medicare. They have received their medical care in other ways throughout most of their life. What is their level of satisfaction or understanding in belonging to an HMO?

Ms. WINTRINGHAM. It is probably difficult for me to answer that question. I assume that they are satisfied because they are staying with the program, and the program continues to grow. Part of the program does mandate a very liberal grievance and review process to assure that medicare beneficiaries have a second resource to turn to if they are not satisfied with the program. It is difficult perhaps for them to turn to us and say they are dissatisfied. But there are sufficient means to protect the beneficiary from that. And we are unaware of any circumstance of that occurring.

I would just point out that there are difficult choices a beneficiary has to make in joining a health maintenance organization under the risk contract. It is certainly easy for an individual who has been with us before and now becomes entitled to medicare. Individuals not previously enrolled in the cooperative do have to give up their community providers, and they do have to accept the lock-in provision which requires that they come to our facilities, use our services and use our practitioners. That is a constraint on them. And the hope is that the incentive side of the program, the reduction of premiums through the efficiencies of the plan, are enough to counteract that disadvantage. Later in the next panel, you will have a consumer member of our organization speak to that, and perhaps that would be a more appropriate person to ask your question.

Senator EVANS. OK, good.

Mr. Wagster, in your testimony you suggest that a critical factor in increasing the number of medicare beneficiaries enrolled in HMO's is to provide sufficient incentive for them to enroll when it means the restriction in freedom of choice in physicians and hospitals that it may generally have under medicare. You go on to say that this requires paying HMO's more than their adjusted community rate for providing medicare-covered services, but will result in HMO members receiving greater benefits than other medicare beneficiaries.

Where would you suggest that rate be set? Are you suggesting that the rate be set at the level a person would have to pay for alternative services to an HMO? And, if so, there are obviously, to the degree you provide services more efficiently or at less cost, an element that can be either used to increase benefits, which acts as an incentive, or presumably to return to the trust fund. Do you have any suggestions for what level at which that original rate needs to be set and where that savings should go?

Mr. WAGSTER. I will try to be responsive. I am not sure exactly how to be specific about responding to your question. But both the problem and the opportunity lie in what we characterize as "savings." The fact is that when an HMO provides comprehensive care, at less total cost than the community fee-for-service—that differential has up to now been simply retained by the Government. And the solution, or the opportunity, that we feel exists and that we think our medicare plus demonstration project showed conclusively can work is this, if that differential is used to cover the HMO's additional benefits not covered by medicare—despite the limitations and restrictions however they are perceived by the prospective members—that 65 and other peo-

ple will in fact enroll in HMO. We enrolled 6,000 of them in a matter of months in the Portland area with just that arrangement under our medicare plus demonstration project.

The savings, then, is the differential between what our adjusted community rate is and the HCFA average per capita cost in the counties involved. But not 100 percent of that differential—at 95 percent of it.

In other words, 95 percent of the total that medicare would expect to pay for fee-for-service medicine for those people in communities. That differential can be used to provide additional benefits, not paid to the HMO for retention by the HMO, but in fact made available to the beneficiary through supplemental benefits as an incentive to join our kind of program despite its lock-in provision. And we feel that has been adequately demonstrated.

As to what benefits you can offer in that package, that is the function of the HMO's cost and a function of the cost of the services which are added to the basic comprehensive package. It is a little bit difficult for me to answer your quesetion specifically.

Senator EVANS. Look at it from the side of Government. We are paying a fee-for-service rate in communities throughout this country. Presumably one of the benefits of moving more strongly toward an HMO would be the greater efficiency and the smaller cost. If we, however, pay the same rate or something close to the same rate, are we achieving any of the savings for the taxpayers as opposed to the increased beneficiaries?

Mr. WAGSTER. The taxpayers by definition would save 5 percent; that is, 95 percent is the maximum of the differential that would result from comparison to the community average. Second, individuals who belong to the HMO's are actually receiving greater benefits and are less apt to be involved in some of the other kinds of social spend-down problems, for example, nursing homes, that later occur by virtue of having less comprehensive benefits available to them than members of an HMO. But the primary savings to the Government is specifically the 5-percent differential.

Senator EVANS. Is there any evidence that you are aware of to indicate that the health care benefits available through an HMO and the way in which people use them leads to any greater health or a longer period of time for the elderly to be independent than someone who is operating under medicare and fee-for-service operation?

Mr. WAGSTER. I am not aware of any study that establishes that, nor am I aware of any study that establishes that there is less health benefit to the individuals that belong to our kind of program.

Senator EVANS. Let us go backward. I have a couple of similar questions for Ms. Wintringham. Are you aware of any indications that the way in which people use health care in an HMO would contribute to greater health than those who would go for a fee-for-service program?

Ms. WINTRINGHAM. Unfortunately, efforts to document that kind of change in outcome or change in health status would require a very expensive, very long—what are called longitudinal studies—studying of population over an extended period of time. I am not aware of any studies that have done that for a senior population.

In fact, the health maintenance organization movement, with the sole exception of Kaiser and Group Health Cooperative and several other plans, has not been old enough to have enough data to have undertaken many longitudinal studies. So, as an alternative, what you do is look at a proxy; you look at cost. And you make sure that short-term outcomes do not differ between two systems. There is a wealth of documented research that shows on both an elderly and non-elderly population—mostly the latter—that practice patterns in a health maintenance organization, particularly prepaid group practices like Kaiser and Group Health Cooperative do have at least the same outcomes at significantly reduced cost. And of course the most recent example of that is the recently published Rand study, which shows substantial differences in cost of treating people in health maintenance organizations, compared to a fee-for-service community. Importantly, the study did carefully adjust to remove any questions about risk selection, which has not been the case before.

So, short of doing a longitudinal study, we are looking at cost and equal outcomes.

Senator EVANS. Is there any indication that people in an HMO use services to a lesser degree or to a greater degree than those on a fee-for-service program, with special emphasis now on the elderly?

Ms. WINTRINGHAM. There is less evidence on the elderly because until this new legislation is put into place, there is not a great involvement of medicare beneficiaries in health maintenance organizations, again with a few notable exceptions.

There is a great deal of evidence that the actual practice patterns in health maintenance organizations differ significantly from the fee-for-service community. The most obvious differences are increased emphasis on health promotion and health prevention, increased use of outpatient settings instead of institutionalizing individuals, and decreased lengths of hospital stays.

In the elderly population, if you look at the example of our risk contract, the cost and use of services on the outpatient setting are equal to or higher than the community, as you would expect. The cost and use of services in the hospital is much lower. That is where the majority of the savings are generated.

Senator EVANS. Good. Back to Mr. Wagster. You indicate also in your testimony that regulations have just been released—why they have taken quite as long as they have, I am not sure, but the period of pregnancy has been inordinately long for this set of regulations. But you say you have prepared comments on the regulations. Do those regulations appear to be generally reasonable now that they have come out? Are they ones which are going to be inordinately difficult to work with? Do you have any general feel or comment on the draft regulations?

Mr. WAGSTER. I think we feel that a reasonably good job was done. But I also think that there are aspects of them that are extremely important to change. We really will not know how workable the regulations will be until we find out how flexible or how accepting the people at HHS are going to be in reviewing the responses to the proposed regulations that we have prepared.[1] We have gone into considerable

[1] See app. 1, item 1.

detail in that regard. The changes are very important to us. And we think our suggestions are workable, however I suspect the original author thought what he was putting out was workable. So, I think time will tell from our standpoint on that.

But it was a reasonably good job. It should have been after 2 years, I suppose.

Senator EVANS. You also suggested that they eliminate the current requirement that two new medicare members have to be enrolled for each existing medicare member converted to a risk contract. I am not quite sure where that came from in the first place.

Mr. WAGSTER. I think I do. The conversion of an existing member results in a 95-percent differential payment—that is, 95 percent of the community fee-for-service cost—rather than what we are now receiving, which is approximately 80 percent of the community cost, somewhere in that general area.

At any rate, the regulations contain the provision that an HMO can offer the package to new enrollees as an incentive to get more people into the HMO's medicare plan, but the existing beneficiaries should be treated the same way they have been. From our standpoint, the full savings continuing to accrue to the benefit of the Government instead of partially to the beneficiary, is simply not equitable. There is a cost aspect here, but there also is an equity issue. The savings money does not end up with the HMO; it ends up in increased services and greater coverage for the beneficiary. But it would be a greater cost to the Government for each of the existing HMO members converted, from the Government's standpoint.

Senator EVANS. It seems to me if I were an existing medicare HMO member, I would collect a compatriot and together we would both get out and then reapply as new members.

Mr. WAGSTER. The regulations have figured that out. [Laughter.]

Senator EVANS. I figured they probably had.

Mr. WAGSTER. They say if you drop out of our health plan, for instance, after we have accepted these regulations and are on a risk basis, that you never can come back as a new member. You come back as the same non-new-member that you were before.

Senator EVANS. So, you really end up with two levels of service availability for HMO members, or is it just that they all get the same benefits, but you get two levels of payment?

Mr. WAGSTER. Two levels of payment. We offer exactly the same services for everyone. But the payment levels would be different. We would have obvious administrative problems. And I think your comment is about what we would expect from our regular members: "This does not make any sense to me. How come I do not get to be treated in the same way that you are treating new members?" It is a difficult situation.

Senator EVANS. Mr. Haugan, I am fascinated by your experiences in Spokane and potential experiences now in other places. You have a long list of services and benefits at Lilac Plaza. What is the average cost to a resident?

Mr. HAUGAN. Because it is low- and moderate-income—and we do have a ceiling on the amount of money people can come—it is dependent on their income. So, about half the people are low income, and they would have to pay 28 to 30 percent, depending on when they moved in. But the basic apartment——

Senator EVANS. I am sorry. Oops, you had better go back. Twenty-eight to thirty percent of what?

Mr. HAUGAN. Of their income.

Senator EVANS. I see.

Mr. HAUGAN. In other words, if they just move in, they pay 30 percent. If they have been there before May 1, 1983, then they pay 28 percent. I think it is something like this. It used to be 25 percent. But basically it is $145 for the apartment, $100 for the meals; $245. If a person's income is higher, the maximum he would pay would be $325 a month at Lilac Plaza. And that is including one meal a day, no maid service. But we have a complete kitchen. So, if you provide three meals a day and maid service, you take away their entire independence. When we started Holman Gardens, we could have it any way we wanted. But we chose to serve one meal a day with the program, and then a cafeteria at noon which is extra. No breakfast. And no maid service except when they need it. Then they pay extra for it. So, that way we can keep the cost down.

Senator EVANS. Is Holman Gardens essentially on the same basis?

Mr. HAUGAN. Holman Gardens for a single person in a one-bedroom apartment would pay $325 a month, including their meal, including the nurse service, including a garden area. It was in the testimony. So, we try to provide a complete range of services for everyone.

Senator EVANS. Is there an initial fee?

Mr. HAUGAN. At Lilac Plaza we were funded under the section 236 program where we had a long-term loan. So, there is no fee there. At Holman Gardens there were no 202 funds available in the Spokane area. So, we had to go to an innovative way, and that is the refundable deposit where the people pay—well, it is $39,000 for their basic apartment, but it is refunded. So, if the person passes away, the heirs get everything back except 10 percent. If there is any appreciation in 10 years, they also get 75 percent of the appreciation. So, it is a new concept. We patterned it after another church group. Maybe this is not the place in this testimony, but a rooster from a henhouse went over to the ostrich farm. And he rolled a big egg over underneath the fence. He called all the hens around and said, "I just want to show you what they are doing at other places." [Laughter.]

So, that is my premise. I go around and I steal ideas from every place I can.

Senator EVANS. And you ended up with the ostrich or the chicken? [Laughter.]

Mr. HAUGAN. Well, I do not know. Maybe I laid an egg. [Laughter.]

Senator EVANS. This has all been really very helpful. I appreciate very much the entire panel. You have contributed a good deal, and some of the extra material you will send in will be very helpful to us.

Mr. HAUGAN. Can I just comment?

Senator EVANS. Yes.

Mr. HAUGAN. You know, you always forget something. In 1978, our State provided $177 million a biennium for nursing homes. In 1982, that figure had jumped to $344 million. It almost doubled in 4 years. I am grateful for nursing homes. But I think that we need the alternative or supplement to it such as we are providing. So, as a gardener

feels good about seeing flowers growing, I feel good about saving money, taxpayers' money.

Senator EVANS. Good. Thank you very much.

Our next panel will speak from the consumers' perspective. Hilde Birnbaum, vice president of the Group Health Senior Caucus; Laurie Jensen, legislative chairman of the Washington State American Association of Retired Persons; and Dr. Dick Ambur, president of the Washington State Medical Association. If those three will come forward.

We will operate in the same fashion we did before. We will hear from each of the panel members, and then we will go into questions.

First, Dr. Hilde Birnbaum, vice chair of the Group Health Senior Caucus. Dr. Birnbaum has an extensive record of involvement with health and long-term care issues on a Federal, State, and currently private level. I have particular pleasure in welcoming Dr. Birnbaum, as she served on the task force on catastrophic health care costs I convened when I was Governor. That was back in 1973. I look forward to learning about Group Health Senior Caucus, how it was formed, and what it is doing.

STATEMENT OF HILDE M. BIRNBAUM, PH.D., SEATTLE, WA, VICE CHAIR, SENIOR CAUCUS OF GROUP HEALTH COOPERATIVE OF PUGET SOUND

Dr. BIRNBAUM. Thank you very much, Senator Evans. My thanks to you, Senator Evans, for inviting me, and my thanks on behalf of the Senior Caucus of Group Health Cooperative of Puget Sound.

The Senior Caucus of Puget Sound was formed to represent seniors in a variety of ways, address their special needs, make them independent, minimize cost, provide advice to the cooperative on their needs. We have among our enrollees 28,000—a little more than 28,000—medicare recipients. And in our Senior Caucus, 900 of those have participated. That is quite a large slice.

We have been recognized by the board as an interest group with special input. And we have been doing two things. We have initiated action, and we have served as a sounding board both to management and the board.

We have particularly worked in two areas: cost containment, which to us also means use containment, and promoted the wellness program.

We have endorsed the risk-sharing program in spite of the fact that it has deprived us of some services that are usually available to beneficiaries of medicare. We cannot go to the Mayo Clinic just because we like to consult them. We are limited to the Group Health facility, and if we are out of the area, we are only covered for urgent and emergency care.

The Senior Caucus also passed a resolution, which I think was sent to you earlier in the year, at their annual meeting in which they took some stands on the cost-cutting of medicare. We would like very much to see that all health costs be controlled rather than just medicare cost and that costs not be rolled over to medicare recipients.

It is regrettable that medicare takes a traditional insurance point of view and excludes prevention and health promotion costs from its cov-

erage. It may be interesting to you to note that the only exception to that rule is the coverage of pneumonia vaccine which was lobbied through Congress by the Center of Health Care Technology at my insistence. However, the Center of Health Care Technology, which has been an institution which very often saved some expenses, has been killed off in the meantime.

Another concern, due to the wording of the medicare and medicaid statutes and regulations, is a built-in bias in favor of institutionalized care. And you, Governor Evans, have recognized that. Entry into a nursing home will make financial support much more likely and better assured than freestanding care at home. Yet home care should be more effective and less costly to society. We at Group Health and the Senior Caucus work to keep people in their homes, try to give them support, help them to change life styles, and wish for provisions in medicare and medicaid legislation recognizing the merits of these activities.

Our wellness program has been a tremendous success. It is now a pilot program, and the demand for it is tremendous. We are training volunteers to serve as wellness teachers, and many of the activities that could take place in retirement homes would be sponsored by that group.

Medicare and medicaid are not well coordinated at this time. And support services to partially disabled or temporarily disabled individuals are generally the first ones to be cut, thus depriving patients of independence and confining them in nursing homes—in most cases for the remainder of their lives.

The Group Health Senior Caucus, Group Health management, and the board of trustees are united in their effort to keep the senior population independent and functioning and to provide a variety of support activities. A Government policy recognizing the validity of this approach would further improve our patient care, reduce nursing home use, and would be fiscally sound and more humane than the present status of legislation.

We have no exact figures about nursing home use by Group Health members since this is not a covered service. But from the figures that I have been able to see, it is about between 2 and 3 percent, a little under 2.5 percent, I would think, of medicare members of Group Health who are presently in nursing homes. That is a little less than half the community average. But those figures are not firm figures. The community is generally estimated at 5 to 7 percent.

What we would like to achieve is more flexibility in the pertinent statutes and regulations. This could lead to a most successful partnership between the Federal Government agencies, State agencies, and our own successful private organization.

Senator Evans, you asked Ms. Wintringham how new medicare enrollees adjust to the HMO coverage our organization provides. Ms. Wintringham mentioned that the consumer representative might be better able to respond to this question. I would therefore like to add that it is my experience, that new enrollees need some guidance in using the system. Some of them have been enrolled at Group Health Cooperative previously through their employment, and hence are well informed and happy to return.

Others have family members who are enrolled and guide them to and through the system. Volunteers from the Senior Caucus are also active in describing options.

Therefore, after a short time of adjustment, we get much praise for our ability to aid seniors, for the comprehensiveness of the coverage, and last, but certainly not least, for the fact that Group Health Cooperative's enrollees are completely free from having to provide medicare or medicare intermediaries with any paperwork. They also appreciate that there has to be no anxiety that a physician's or provider bill might be fully or partially disallowed. They praise the peace of mind the HMO coverage gives them.

Thank you very much.

Senator EVANS. Thank you very much Dr. Birnbaum. Your full printed statement will be included in the record.

[The prepared statement of Dr. Birnbaum follows:]

PREPARED STATEMENT OF HILDE M. BIRNBAUM

My name is Hilde Birnbaum. I am testifying here as vice chair of the Senior Caucus of Group Health Cooperative of Puget Sound and want to express my appreciation and the appreciation of the Caucus for being heard.

By profession, I am a consultant on economics and professor emeritus of economics.

My pertinent experience includes: Service on the board of Group Health Cooperative of Puget Sound, 1955–60 and 1962–78; president of Group Health Cooperative for four terms; member of the board of Group Health Association of America, 1967–79; member of Governor Evans' Task Force on Catastrophic Health Care Costs, 1973–75; member, National Council on Health Care Technology, Washington, DC, 1979–82; member, coverage committee, National Council on Health Care Technology, 1980–82; member, Visiting Committee School of Public Health and Community Medicine Study, 1971 to present.

The purpose of the Senior Caucus is clearly spelled out in its constitution (appendix A). The main points are:

To enable older consumers, as a group, to formulate and express opinions and recommendations concerning their welfare and health care.

To work toward the attainment of services and facilities that will enhance the health and welfare of older people as well as all other Group Health consumers.

To encourage older consumers to participate more fully in their own health care.

To minimize medical costs for older consumers.

To provide a vehicle through which to channel action or advice on any issue before the Cooperative. (For entire contents, see Appendix A.[1])

The Caucus has an active and participating membership in excess of 900 individuals and more than 28,000 Group Health members age 65 and over are interested in its activities. The board of Group Health has officially recognized this group as a special-interest group. We have focused our intention on needs specific to the older population. In addition to our own initiative we have actively served as a sounding board for Group Health management and the board when decisions pertaining to older consumers were contemplated.

In particular, we have initiated work to keep health care for an aging population affordable, without putting an undue burden on Group Health Cooperative as an organization or on individual Cooperative members. For this reason, we have endorsed the risk-sharing contract, although it deprives us of some choices which most medicare beneficiaries enjoy. (If in the service area, we have to use Group Health facilities and physicians, outside the service area we are only covered for urgent and emergency care.) We are proud that Group Health can provide health care at a cost 25 percent lower than the surrounding community.

[1] Retained in committee files.

We also believe that we each have an obligation to our own wellness. As a Caucus, our activities have centered in keeping seniors healthy, effective, and able to take responsibility for their health. Our pilot "wellness program" has not only been well received, but has resulted in a tremendous demand for expansion. It is a direct result of the Senior Caucus request that preventive health promotion and assistance to stay independent are not only healthy for individuals but also a saving for Group Health Cooperative and our society.

We are painfully aware of the fact that medicare enrollees generally pay their group health and medicare B dues out of their own pockets and that this means that comprehensive coverage for a family of two seniors amounts to an expense of about $110 a month, less than other medigap insurance but still a large slice of average incomes. (See Senior World, May 1984.)

We are concerned that the ever increasing costs, due in large part to increases in deductibles and coinsurance under medicare legislation, are pricing a number of enrollees out of the system. This is particularly likely in the case of people in the twilight zone, too poor to pay these dues and too rich to be eligible for medicaid.

At the annual meeting of the Senior Caucus, March 17, 1984, we passed a resolution urging Congress to control all health care costs, rather than depriving medicare recipients of benefits and rolling the cost over on medicare enrollees. Since then congressional action has increased deductibles. More such cuts seem to be contemplated and—in our opinion—will be counterproductive by squeezing individuals out of the private sector and into medicaid programs. (Appendix B, Senior Caucus resolution.)

It is regrettable that medicare takes the traditional insurance point of view and excludes prevention and health promotion cost from its coverage. The only exception to their rule is the coverage of pneumonia vaccine lobbied through Congress by the Center of Health Care Technology at my insistence.

Another concern due to the wording of medicare and medicaid statutes and regulations is the built-in bias in favor of institutionalized care. Entry into a nursing home will make financial support more likely and better assured than free-standing care at home; yet home care should be more effective and less costly to society. We at Group Health and the Senior Caucus work to keep people in their homes, try to give them support, help them to change life styles and wish for provisions in medicare and medicaid legislation recognizing the merits of these activities.

Medicare and medicaid are not well coordinated at this time and support services to partially disabled or temporarily disabled individuals are generally the first ones to be cut, thus depriving patients of independence and confining them in nursing homes, in most cases for the remainder of their lives.

The Group Health Senior Caucus, Group Health management, and the board of trustees are united in their effort to keep the senior population independent and functioning and to provide a variety of support activities. A government policy recognizing the validity of this approach would further improve our patient care, reduce nursing home use and would be fiscally sound and more humane than the present status of legislation.

More flexibility in the pertinent statutes and regulations could lead to a most successful partnership between the Federal Government agencies, State agencies, and our own successful private organization.

Appendix B

Medicare Resolution

SUBMITTED TO THE ANNUAL MEETING OF THE SENIOR CAUCUS BY THE SENIOR CAUCUS EXECUTIVE COMMITTEE, MARCH 17, 1984

Whereas there are about 28,000 older consumers in Group Health who are insured by medicare and who pay monthly premiums to medicare as well as health care dues to Group Health, and

Whereas medicare currently pays for only about 40 percent of the health care costs of these Group Health enrollees and some 26 million older Americans who have medicare coverage, and

Whereas a number of proposals have been made by President Reagan's Advisory Council on Social Security and Medicare which, if adopted by Congress, would result in even higher out-of-pocket health-care costs for all older Americans, would affect adversely or lower the quality of health care and would disrupt the present medicare heatlh-care delivery system,

Whereas these proposals by the President's Council would deal only piecemeal with medicare financing problems rather than with the overall issue of how to contain costs of the entire Nation's health care delivery system, and

Whereas these proposals and other proposals being considered in Congress would in effect attempt to reduce the Federal Government deficit by placing a heavier and unfair financial burden on the poor and sick elderly, and

Whereas Group Health was one of the initial supporters of medicare as a health care underwriter and provider for older Americans, and

Whereas Group Health continues to favor good quality health care for all Americans, therefore

Be it resolved that the Senior Caucus of Group Health Cooperative record its opposition to proposals which would reduce benefits and coverage and increase costs for Americans now insured by medicare, and

Be it further resolved that the Senior Caucus, on behalf of the 28,000 medicare enrollees in Group Health, ask the present members of the Washington State delegation in Congress, all Presidential candidates and all candidates for congressional seats from our State in the 1984 elections to oppose such proposals, and instead sponsor and support legislation to preserve and enhance the quality of the Nation's health care system and to halt runaway health care costs, and

Be it further resolved that this annual meeting call on all enrolled consumers of Group Health to write to their Congressman and Senators expressing their individual support for the sentiments of this resolution.

Senator EVANS. Next, Laurie Jensen from the Washington State American Association of Retired Persons. She is legislative chair of the State chapter and a member of the advisory council of the Seattle-King County Division of Aging, also a member of the Washington State Senior Lobby Board of Directors. In 1980–81, she served as Congressman Pritchard's senior intern and in 1981 was a delegate to the White House Conference on Aging. I am very happy to have you in front of the committee.

STATEMENT OF LAURIE JENSEN, SEATTLE, WA, CHAIR, WASHINGTON STATE LEGISLATIVE COMMITTEE, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mrs. JENSEN. Thank you, Senator Evans, for this opportunity to share with you the American Association of Retired Persons [AARP] deep concerns about the alarming escalation of total health care spending the need to develop on a National scale a strong community-based continuum of long-term care.

From the elderly's point of view, a most significant issue in the field of aging is long-term care. Four trends underline the need for development of a comprehensive LTC system: growing aged population, increasing life expectancy, chronic disease as a dominant pattern of illness, and changing family patterns.

Having reached 73.5 years of age, I can speak with immense authority about the elderly consumers' concerns. We are a diverse group with diverse needs for accessible, affordable health care delivery systems. I get pauper paranoia and anxiety attacks when I read the heart-starter statistics on spiraling health costs. We need quality assurance and need to be asured there will be more measure of financial protection. The elderly are the most cost-conscious health care consumers in this country. We have to be. We are not insurance insulated, as are some of the present workers. Fewer and fewer of us are financially able to retain supplemental policies because of the high cost of insurance premiums. The deterioration of medicare's protection frightens us. We wish to live in the least restrictive environment, and do not

want to be institutionalized in dependency fostering settings. Our plans are for relief from the complexities and confusion of the present health system.

Unquestionably we have established the need for an LTC system. Let us address the how's and the who. What level of income shall be required to become eligible for Government benefits? And we would hope these would be flexible. Who gets access. Who will deliver? Who will do the screening and case management? AARP feels that an evaluation of demonstration projects such as the social/health maintenance organizations can provide hard data and ensure final decisions are uniform. Medical care must be integrated into the overall care to correct serious gaps in both indepth assessment of patients and delivery of service.

Social/health maintenance organizations demonstration projects are just beginning. These are case-managed type systems. Under the S/HMO—and I just realized that as a buzz word that would come out "shmoe." [Laughter.]

Under S/HMO a wide range of services, both medical and social, would be centrally accessable to the individuals having serious functional disabilities and impairments. This is especially important for the chronically ill who's medicare coverage is at best minimally supplemented by the so-called medigap insurance policies. Dollars are strong powerful medicine. So, AARP supports the HMO concept because they are accountable to their enrollees for the cost, quality, and availability of services, and they stress appropriate use of a range of services. They coordinate care. Less costly alternatives to acute care. Less intensive. Less expensive.

HMO's also hospitalize about 50 percent less patients. So, thus, if we are concerned about secondary demand, a type of case-managed system may well allow for expanded benefits to enrollees at no additional cost to the public third-party payers. This larger type system implements the insurance principle of spreading the risk over a larger population paid for by a combination of enrollee payments.

By this time I think everyone here will agree old age is not for sissies. [Laughter.]

Health care cost containment is an overlap in the LTC picture. We are not seeking culprits, but rather solutions. There is enough blame to go around. We are all at fault—government, health providers, and consumers.

Mark Twain said it so beautifully, that nothing concentrates a man's mind more wonderfully than knowing he is going to be hanged. And I feel health care cost is placing a noose around our neck.

The AARP legislative program advocates a national cost-containment strategy that has four basic objectives:

One, rate of increase in hospital expenditures should be limited; and this limit, once established, should apply to all third-party payers.

Two, economic incentives that are causing excessive expansion of conventional medical facilities should be removed.

Three, government regulatory programs with a potential to yield significant savings should be promoted, along with effective measures to promote healthy competition.

Four, health care service delivery should be restructured away from acute care institutional settings.

Let us talk about the family unit. It is an important contributor of supporting services to the Federal income tax credits which should be made available. State and Federal Government should work in partnership to expand congregate care housing, respite care projects, recruit more adult family homes, expand funding for in-home services, support home-sharing projects, support adult day care centers, explore supervised living or sheltered living arrangements.

DRG's—diagnosis related groupings—are felt to be a step in the right direction. Caveats, however, include surge of more skilled needs in nursing homes because of the early discharge of sicker and sicker patients. As a part of these inefficiencies to be considered in hospitals, underutilization could be a thrust, step down or swing beds in wings for reduced care.

The negative spinoff of too early discharge may lead to a second level of care. This must be carefully monitored. This prospective payment method, governing medicare's payments, can help dampen the rate of increase in hospital costs only if it is extended to all third-party payers, and must be reinforced by a strong quality review followup.

Consumers: as consumers we all have responsibilities. We share in the intergovernmental relationship with health providers. We can reduce health care costs by becoming prudent patients. Adam, in the Garden of Eden, asked Eve, "Do you love me?"

Eve replied, "Who else?" [Laughter.]

We have choices. We can make cost-based choices. And in my written testimony I have listed at least 15 ways.

Prevention, let us accent that, instead of crisis intervention. That is good medicine.

Choose more healthy lifestyles, establish good habits in nutrition, diet, exercise. Be aware of the so-called avoidable risks: obesity, smoking, alcoholism. With every healthcare dollar spent, 97 cents goes for treatment of disease. Only 2½ cents for prevention and only a one-half cent goes for health promotion.

I have statistics that I would request be given to the—these are compiled by the AARP—and be given to the Senate Special Aging Committee.

Senator EVANS. They will be entered into the record.[1]

Mrs. JENSEN. Fine. Thank you.

Aging means not much time left. We older adults can only pray for a reasonable rate of decline so we may work as advocates toward an affordable, rational—not rationed—LTC system. We are traveling hopefully with strong, decisive leadership. Our country was built on hard, tough decisions. Our sunset years will have quality, dignity, and purpose. Working together we can find a potent prescription to cure our health care dollar disease.

We can reverse unhealthy health costs and long-term care complexities, sure. Prognosis favorable. We pledge AARP's support, and we will exercise our influence in legislation, information dissemination, and education.

And, one more time, thank you.

Senator EVANS. Thank you very much. That was splendid testimony.

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[1] See prepared statement of Mrs. Jensen.

[The prepared statement of Mrs. Jensen follows:]

PREPARED STATEMENT OF LAURIE JENSEN

Thank you, Mr. Chairman, for this opportunity to share with you the American Association of Retired Persons [AARP] deep concerns about the alarming escalation of total health care spending and the need to develop on a national scale, a strong, community based continuum of long-term care services.

My name is Laurie Jensen, chair for the Washington State Legislative Committee of the AARP and member of their cabinet for region IX. AARP national membership is over 17 million and State membership over 260,000. Using the happy alphabet soup jargon of today, the AARP is RWA—ready, willing, and able—to work collaboratively with our decisionmaking legislators, provider groups, universities, business representatives, organizations, hospitals, nursing homes and physicians to address the complex problems of long-term care and health care cost containment.

From the elderly's point of view, a most significant issue in the field of aging is long-term care. This includes a coordinated array of social and health services provided in a variety of settings, from institutions to private residences. Four trends underlie the need for development of a comprehensive LTC system: (1) Growing aged population; (2) increasing life expectancy for the elderly; (3) chronic disease as dominant pattern of illness; and (4) changing family patterns.

Having reached 73.5 years of age, I can speak with immense authority about the elderly consumers' concerns. We are a diverse group with diverse needs for accessible, affordable health care delivery services. We are fiercely independent and my personal goal is to come out even with my money. I get pauper paranoia and anxiety attacks when I read the heart starter statistics on spiraling health costs. We need quality assurance and need to be assured there will be some measure of financial protection. The elderly are the most cost-conscious health care consumers in this country. We have to be. Fewer and fewer of us are financially able to retain supplemental policies because of the high cost of insurance premiums. The deterioration of medicare's protection frightens us. We wish to live in the least restrictive environment, and do not want to be institutionalized in "dependency fostering" settings. And our pleas are for relief from the complexities and confusion of the present health care system.

We would like to see incentive grants to health profession schools to encourage training and curriculum development in geriatrics. (Perhaps subsidize training of those health professionals who agree to work in medically underserved areas.) We hope physicians would be encouraged to become more sensitized to the needs of the chronically ill, and in their regulations toward quality care they would weed out negligent providers by license suspension or revocation and thereby reduce malpractice judgments and premiums. Also, bring their fees in line with what we can afford. We would like to see basic professional fee schedules for doctors and laboratories standardized. At present, there is a wide variation for treating and testing similar conditions.

Unquestionably we have established the need for an LTC system that encourages the linkage and coordination of management of services within the community, providing not just institutional care, but a complete continuum of services, including home-based and community-based services. Let's address the "how" and "who." What level of income shall be required to become eligible for government benefits? (We elderly are willing to swallow some bitter medication—cuts, copayments, etc—but feel an equal dosage—sharing of the burden should be prescribed for all providers.)

Who will deliver? Who will do the screening and case management? AARP feels evaluation of demonstration projects, such as social/health maintenance organizations or case managed systems can provide hard data and ensure final decisions are uniform. Medical care must be integrated into the overall care to correct serious gaps in both in depth assessment of patients and delivery of service.

Social/health maintenance organization demonstration projects are just beginning—case-managed systems. Under the S/HMO, a wide range of services, both medical and social, would be centrally accessible to individuals having serious functional impairments. (Especially important for the chronically ill whose medicare coverage is, at best, minimally supplemented by privately arranged "medi-gap" insurance policies.) Dollars are strong medicine and these case-managed type programs are cost conscious. Enrollees pay a fixed premium in ad-

vance—no large deductibles or copayments are charged patient. In addition to primary case and specialty medical care, these centers offer laboratory, x-ray, pharmacy, hospital care, and health education—practice preventive medicine. The AARP supports the HMO concept because they are accountable to their enrollees for the cost, quality and availability of services, and they stress appropriate use of a range of services. They coordinate care, less costly alternatives to acute care, less intensive, less expensive.

The S/HMO case-managed programs, are intended to correct the problems of access (caused by fragmentation of services) and will assure an appropriate mix of services through the creation of an organized delivery system and financing plan that maximizes both provider flexibility and accountability. Thus, if we are concerned about secondary demand, a type of case-managed system may very well allow for expanded benefits to enrollees at no additional costs to the public third-party payers. This larger type system implements the insurance principle of spreading the risk over a larger population paid for by a combination of enrollee payments.

By this time I think you will agree—old age isn't for sissies.

Health care cost containment is an overlap in the LTC picture. We are not seeking culprits, but rather solutions. Heaven knows there is enough blame to go around. We are all at fault—government, hospitals, physicians, health providers, and consumers.

The AARP legislative program advocates a national cost containment strategy that has four basic objectives:

(1) Rate of increase in hospital expenditures should be limited to a fixed percentage rate that is reasonably in line with general inflation rate; and this limit, once established, should apply to all third-party payments to hospital. Also, restrictions on increase in physician fees must be imposed—bring incomes into line with that of nonmedical professionals.

(2) Economc incentives that are causing excessive expansion of conventional medical facilities should be removed, for example, by imposing limits on depreciation deductions when hospitals/nursing homes are sold.

(3) Government regulatory programs with the potential to yield significant savings should be promoted along with effective measures to promote competition in the health care industry.

(4) Health care service delivery should be restructured away from acute care institutional settings, with greater emphasis placed on community and home-based services and be made more responsive to consumer needs.

ALTERNATIVES

The family unit is an important contributor of supporting services and Federal income tax credits should be made available to provide taxpayers with incentives to care for their dependent elderly at home and we should fund and expand respite care. State and Federal governments should work in partnership to expand congregate care housing; recruit more adult family homes; expand funding for in-home services; support home sharing projects; and support adult day care centers.

Legislation must be passed to put the brakes on out-of-control unhealthy health care costs. Today, older persons are paying as much in out-of-pocket costs (15 percent plus) as before the implementation of medicare. The root cause of the health care cost crisis is the structure of the health care system itself. It promotes inflation. It rewards doctors and hospitals with more and more income for providing more and more care (whether needed or not); expansion and more costly equipment (whether needed or not); inefficiency and waste are not penalized so reasonable, realistic limits must be legislated.

DRG's are felt to be a step in the right direction (prospective payments as opposed to fee-for-service). Too early to assess, however. Caveats include surge of more skilled needs in nursing homes because of early discharge of sicker and sicker patients. (As a part of the inefficiencies to be considered in hospitals—underutilization could be a thrust. Step down or swing beds in wings for reduced care (and less expensive). Research unnecessary duplication of facilities existing in hospital sector as these should be consolidated and shared.) The negative spinoff of too early discharge, then costly reentry, may lead to second level of care. These must be carefully monitored. Note: This prospective payment method governing medicare's payments to hospitals can help dampen the rate of increase in hospital costs only if it is extended to all third-party payers, and must be reinforced by a strong quality review component.

With the nursing home industry and hospital's attack of "acquisition fever," legislation must be passed to prohibit or limit hospitals and nursing homes from revolving or "stepping up" value of their properties to reflect purchase price at the time of sale or merger so they can then use the higher basis on which to depreciate the asset and these subsidies (allowance for depreciation and interest at higher value) directly increase medicare's payments for capital costs.

CONSUMERS

As consumers we have responsibilities. We share in the intergovernmental relationship with health providers. We can reduce health care costs by becoming prudent patients. As smart consumers we can make cost-based choices. For instance: We can seek second opinion when surgery is suggested; inquire about same day or outpatient surgery; ask doctors regarding fees and whether he/she accepts medicare assignment; avoid entering hospital on weekend; make certain tests to be done in hospital have not already been performed; use emergency room of hospital only when a true emergency exists; inquire about emergicenters in the community; use generic drugs when possible; check into use of HMO's or PPO's (prepaid discount programs) for cost savings; make greater use of ambulatory clinics; check outpatient rehab units; use geriatric nurse practitioners; be educated regarding home health services available; and do comparative shopping for eyeglasses, hearing aids, etc. AARP pledge to increase availability of their brochures and publications re consumer information.

PREVENTION INSTEAD OF CRISIS INTERVENTION

That's good medicine. Choose more healthful lifestyles—establish good habits in nutrition, diet, exercise; be aware of avoidable risks (obesity, smoking, alcoholism); attend stress management and stress control classes, etc.

Industry is concerned about the dramatic increase in cost of health care benfits for their employees. (Workers have a stake here also as they are facing possible cutbacks in their health insurance coverage.)

Insurance companies are alarmed about spiraling premiums, and looking for alternatives to costly and inappropriate health care services. Since 1975, private health insurance premiums have increased 130 percent. We must track needs, not demands.

AARP urges Federal and State authorities to cooperate and develop and implement a comprehensive and coordinating plan to detect and prosecute medicare and medicaid provider fraud.

Medical technology needs a council to establish restraints and evaluation and this assessment should be included under authority of National Center for Health Service.

My organization has compiled statistics and we request that these be shared with the Senate Special Committee on Aging.

Aging means not much time left. We older adults can only pray for a reasonable rate of decline so that we may work as advocates toward an affordable, rational (not rationed) LTC system. We feel what we gain, what we protect now will be our young citizens' inheritance.

We are traveling hopefully and with strong, decisive leadership (our country was built on hard, tough decisions) our sunset years will have quality, dignity, and purpose.

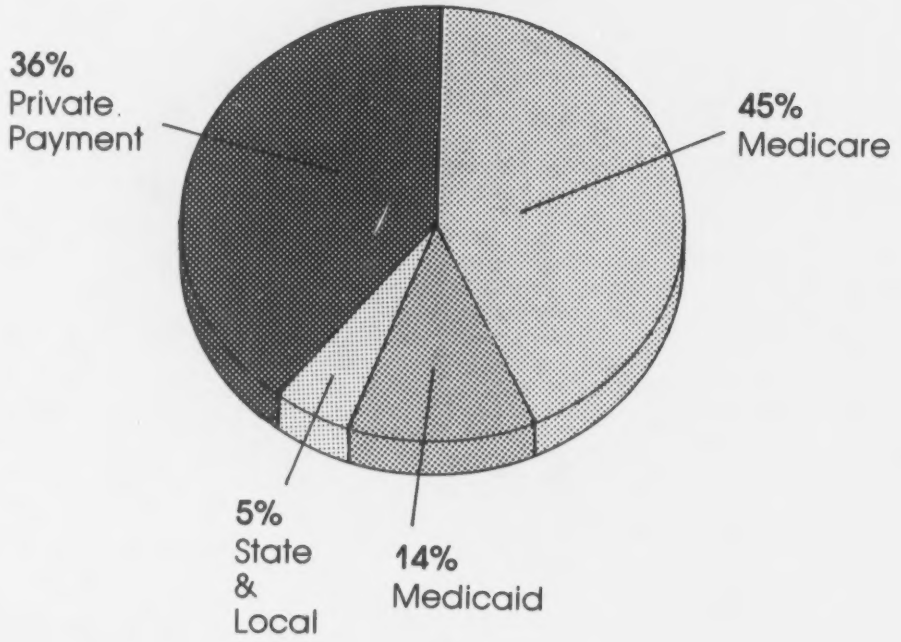
Working together we can find a potent prescription to cure our health care dollar disease.

Prognosis favorable.

We pledge AARP support and will exercise our influence in legislation, information dissemination, and education.

One more time, thank you.

Who Pays for Older Persons' Health Care?
1982



Source: Health Care Financing Administration

Growth in Per Capita Elderly Consumer Payments for Health Care 1977 — 1984

Source: Health Care Financing Administration; American Association of Retired Persons

ANNUAL HEALTH CARE PAYMENTS MADE BY THE AGED

	Per Aged Person	Payments as a Percent of Income
1966 (Pre-Medicare)	$300	15%
1977	$698	12%
1981	$1198	14%
1984	$1550	15%
1989	$2208	16%
1993	$2892	17%
2000	$4637	19%

Source: Health Care Financing Administration; American Association of Retired Persons

Potential Impact on Elderly If Medicare Deficit Is Shifted to Hospitalized Beneficiaries

	1983	1995	1995
	Current	Projections[1] Based on Current Law	Projections[1] Based on Shift of Deficit to Hospitalized Beneficiaries
Cost of Average Hospital Stay[2]:	$304 + 0	$800 + 0	$800 + $4300
Total Elderly Consumer Payments for Health Care[3]:	$1455	$3310	$7610
Per Cent of Income:	14.5%	17%	40%

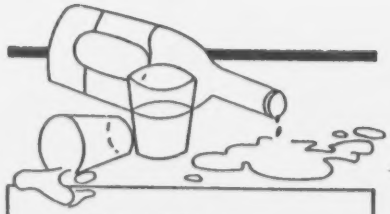
Sources: Robert Myers Memorandum, September 23, 1983; Thomas C. Borzilleri Memorandum, November 4, 1983

[1]Based on Trustees' Alternative II-B assumptions.

[2]Defined here as Part A Deductible and Part A Coinsurance (excudes physician services provided in hospital).

[3]Mean per capita figure including out-of-pocket costs plus premium payments.

COSTS OF UNHEALTHY LIFESTYLES

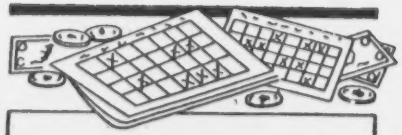


- **$19 billion** in lost workdays due to alcoholism

Wellness at Work, Cunningham, 1982

- **$4,611 in costs to an employer for each smoking employee** in medical costs, absenteeism and decreased production

"Smoking: A Challenge to Worksite Health Management." Klefhaber and Goldbeck, 1981

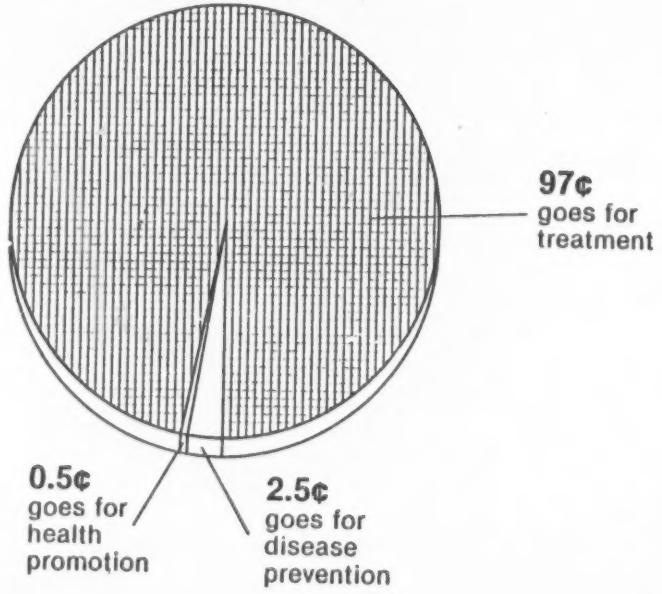


- **30 million workdays and $2 billion in lost earnings** in 1980 due to hypertensive diseases

National Heart, Blood and Lung Institute

HEALTH PROMOTION: AN IGNORED PRIORITY

For every health care dollar:



Source: "A National Health Care Strategy", Vol. 4.
Sehnert and Tillotson, National Chamber Foundation, 1978.

Senator EVANS. Our final scheduled witness is Dr. Dick Ambur, president of the Washington State Medical Association. He has been a member of the board of trustees of that organization for the past 10 years, and he has been very active with several civic and State associations dealing with health and long-term cost care containment. Dr. Ambur.

STATEMENT OF DR. RICHARD F. AMBUR, SEATTLE, WA, PRESIDENT, WASHINGTON STATE MEDICAL ASSOCIATION

Dr. AMBUR. Thank you, Senator Evans. When you are the last one on the panel, you think that maybe somebody is going to say everything you have had to say or plan to say and there is nothing left, or you get a lot of food for thought so that you can talk back. One thing I am very happy about is for once in my life I am now listed on the consumer side instead of the provider side. So, I am now a consumer representative. My mother will be thrilled about that. [Laughter.]

Senator EVANS. There is hardly a physician alive that at one time or another does not become a consumer of your own services.

Dr. AMBUR. Right. In our written testimony we have submitted a paper which describes the projected increase in the number and the particular needs of the elderly during the next several decades. We have supplied this information to all of our physicians—actually throughout the country, not just throughout our State—so that they will be more aware of the problems that we are facing and the key issues in the delivery and the financing of care for the aged.

I would like to just address in the oral remarks a couple of questions that you asked in your letter to our association and then perhaps answer some of them. I am sitting in sort of a dilemma here. As the president of the association, I represent all of the physicians in the State. And sometimes as a fee-for-service practitioner, I represent the fee-for-service as opposed to the closed panel model. So, I have to be a little bit careful in my official remarks.

The changing nature of the elderly's demands or needs, rather, is that they are living longer, as has been mentioned here on several occasions. And, as you live longer, the machine begins to break down and you do need more repairs. And that gets to be expensive. As we all know, you can buy a new car sometimes for a lot less than you can replace all the parts of the old one. While the body is much better at repairing itself, sometimes the parts get to be expensive in replacing them.

I think that the physician population will be able to meet without any great deal of difficulty the acute care medical needs of chronic illness for the elderly. I do not see that that will be a great problem as far as numbers of physicians into the next century, as a matter of fact.

As far as adapting to the changing nature, we are a service profession and have a history of being able to adapt to what the patients need and require. And we will meet that without any particular difficulty.

When speaking of models to treat the chronically ill, I think in our State we have shown, at least on the acute side of this problem, that between the closed panel models that have developed a very efficient system and even the fee-for-service, which has the bureau system,

which is basically an HMO since it is a capitation payment, we have shown in this State that we can meet the needs of people and at an efficient cost-effective level. I think we will be able to do that, if given the opportunity to work with you in the long-term care.

So, I would try to keep away from one specific model as being the best model and rather retain some flexibility, as I think I have heard most of the speakers mention here today.

I think as far as an incentive for the physicians to go along with this, that the flexibility would be the greatest incentive. Our concern usually—with the elderly and the people with long-term illness—is, what happens to them after we have taken care of the immediate acute problem so that they do not have to come back to us?

We are one of those few groups that try to keep people away from us, and most people like to have you come back and get more and more business. But we do try to get you well so you do not have to come back and see us.

But what happens after you have broken your hip or have a heart attack or something of that nature? This is the dilemma that we run into in the hospitals now, but I think in our State we are beginning to make some inroads in that problem. Most hospitals do have now social service coordinators who find out what is available in the community, what there is in the way of help for people, so that if possible you can keep them out of the strictly institutionalized setting.

From the perspective of somebody who has been practicing for over 20 years, most of my elderly patients are concerned primarily about becoming a burden either to their family specifically or to society in general, and concerned that if they are going to live for a while longer, they do not want to live stuck in a little 2-by-4 cubicle and not be able to enjoy themselves, especially if they have enough capacity left that all they need is a little bit of help. I have lots of people who could go home if somebody would just come and check up on them now and then or somebody could do the shopping or do the chores that they cannot quite handle. This is the flexibility that most physicians would like to see in the system for taking care of long-term illness. We cannot handle that. We have enough to do with the acute care illness problems, but we will be happy to work and give our thoughts and suggestions as to a solution to it. Thank you.

Senator EVANS. Thank you very much.

[The prepared statement of Dr. Ambur follows:]

PREPARED STATEMENT OF DR. RICHARD F. AMBUR

The medical profession welcomes the further development of the partnership for long-term care that now exists in both the private and government sectors in the State of Washington. Improvement, encouragement and innovative change are needed and this hearing can contribute to this end.

We are submitting for the record a paper which describes the projected increase in the number and particular needs of the elderly during the next several decades. This information has been widely circulated within the medical profession to provide physicians with an understanding of the key issues and developments in the delivery and financing of care for the aged in order that doctors will be better able to respond to the changing environment described.

We are also submitting a paper which outlines the activities of the joint task force of the American Nurses Association and the American Medical Association on Health Care for the Aging and the Aged. We feel it is essential that attention be paid to the key role of the nursing profession in long-term care. In this regard, we refer you to a 1980 joint project of the Washington State Nurses Association

and the Washington State Medical Association, entitled "Collaborative Practice in the Nursing Home Setting," Kathie Moritis, R.N., M.N., principal investigator.

Excellent acute care for the elderly is available but it is obvious economic barriers to obtaining care exist. These are being addressed in many ways and more needs to be done. But the chronically ill, the terminally ill, and those who require a very long time to recover from major acute care experiences present different problems. There is a need for a Federal-State-private partnership effort to look carefully at ways existing government programs deal with many chronic conditions. These programs need to be restructured to better meet the needs of our older citizens both from the viewpoint of care and treatment methods and program eligibility.

This brings me to comment on what doctors are hearing from their older patients regarding their needs and wants. Time does not permit detailed discussion of this most important subject, but to generalize, physicians today are seeing a great deal of change take place in the elderly persons' demands for health services. Putting acute care aside, physicians find their elderly patients concerned about possible chronic disease, concerned about a debilitating aging process and possible terminal illness and the care needed for these. Doctors also hear their patients wanting to have their own doctor, and the freedom to go to another doctor if they feel a change will be more help to them in regaining good health. As mentioned earlier, physicians hear from their patients about their economic concerns, being a burden to their children, and a feeling they are victims of an inflation that eats away their fixed incomes. Physicians—and other health professionals—find it difficult to deal with the admirable determination and hope manifested by many elderly people that they will be well and feel good again, particularly in those situations where all indications are to the contrary. These attitudes, needs, and demands on the part of many elderly patients, when combined with the total and global problems connected with long-term care, cry out for action in developing a comprehensive science and art of geriatrics. This is a need that should be taken on a Federal-State-private effort, right here in the State of Washington.

All health professionals, and among physicians, family doctors and internists, need continuing education in geriatric medicine.

There was an upsurge of interest in geriatrics but this got lost in subsequent years as other health and medical targets were selected. But there is a new direction being taken. Here in the State, we have one of the first and probably the best of innovative geriatric teaching and research centers. It is located at Harborview Hospital under the auspices of the University of Washington School of Medicine. This is a multidiscipline approach and its program will provide a new and important geriatrics component in the medical school curriculum and future physicians will be prepared to be effective in long-term care. But more than this is needed. That geriatric center can produce continuing education and consultations to physicians and other health professionals who are practicing now—but only if that program continues. Here is where the health insurance industry, health professionals, State government, Federal Government, and elderly citizens can join in a partnership to make sure the Harborview Geriatric Center survives and thrives. This means the DRG system of medicare payment for hospital services at that teaching and research hospital will have to receive special attention from the State Hospital Commission, third-party payers, medicare and medicaid. An initiative is needed to assure the continuation of our geriatric center and others that have started up in other parts of the country all of which are threatened with extinction in the current cost reduction trend. Without a basic science and art of geriatrics problems in long-term care will mount regardless of delivery system experiments.

It is important to stress that geriatric training and research centers deal with all kinds of health practitioners, administrators, and the elderly themselves. Investment in them today will result in great strides toward a future long-term care system that all of us want. Doctors, nurses, and other health professionals will be enthusiastic about a basic science and art of geriatrics that can come to them from such centers. The question has been asked whether the growth in the elderly population will require more doctors. It will be important to continue health personnel studies to assure a supply adequate for both acute and long-term care. But the geriatric research and training centers, if assured continuation, will provide physicians and other health professionals being able to adapt to the needs of the changing population in an effective and efficient manner.

The question has been asked whether there is a preferred model for treating the chronically ill. The evidence as contained in the literature on the subject tells us we simply don't know but that we must try to find out. We have stated that all alternative financing and delivery systems for providing long-term care should be tried and should compete in the political and the consumer marketplace. These include cost-sharing and catastrophic health insurance coverage; life care communities; fine tuning of our majority system of physician-nursing-hospital-nursing home services; social health maintenance organizations; upgraded nursing homes; visiting nurse services; hospices; and chore services. However, without a new and improved science and art of geriatrics worthy of that name we are likely to be putting a series of bandaids on the provision of long-term care without getting at the roots of the situation. Energy needs to be unloosed in the long-term care field. An emphasis on the art and science of geriatrics is an important step in splitting the long term care atom.

A final comment. We see no ultimate improvement in long-term care if the current reaction or over reaction to health care cost rises continues. The cost rise curve probably already has been altered due to all of the emphasis on cost containment in recent years. Are we sure we have our priorities right? With the cost of tobacco, alcohol, and entertainment reported as equaling 25 percent of the gross national product would it be rational to expect health care expenditures to equal for 18 to 20 percent of the GNP?

Excerpt from Reports of AMA Annual Meeting, June 1983

Health Care for the Aging and the Aged: AMA-ANA Task Force Study and Other AMA Activities

PURPOSE

The purposes of this report are to reaffirm the AMA's commitment to address medical and other health care of the aged, to report on the recommendations of the AMA-ANA task force, and to describe AMA initiatives in this area. This report is offered for information.

INTRODUCTION

Medical and other health care of the aged present a major challenge for the medical profession. The issues surrounding the provision of medical and other care to this segment of our population are multifaceted, encompassing many difficult questions concerning science, ethics, and quality of and access to care. The challenge and the issues can be expected to grow in proportion to the growth of the aged population—a population that increases more rapidly than the population as a whole. For example, in the next 50 years, the total population is expected to increase by 40 percent. However, the population over 65 years of age will more than double in that same period of time, and the population over 75 is expected to more than triple. As the proportion of older people in the population increases, the requirements for acute and long-term care will increase.

The needs for care of and services to the aged often go beyond the purview of the health care professional. However, the medical profession will be deeply involved with many of the emerging health care issues resulting from the projected increase in the numbers of aged, and in the subsequent demands placed on all aspects of the provision of medical and other services. The AMA is laying the foundation to address these needs through the initiation of several projects, and through participation in a joint American Medical Association-American Nurses' Association task force.

AMA-ANA TASK FORCE

A recent cooperative effort of the American Medical Association with the American Nurses' Association focused on the specific problems of chronic illness in elderly people. In March 1981, an AMA-ANA leadership group convened to discuss national health issues of mutual concern. The group identified as an issue of primary importance the urgent need to improve care for the aged chronically ill. A joint AMA-ANA Task Force to Address the Improvement of Health Care of the Aged Chronically Ill was appointed in January 1982. The task force was composed of four physicians and four nurses appointed by the AMA and ANA, respectively, on the basis of their expertise in caring for people who are elderly and chronically ill.

In early 1983, the AMA-ANA leadership group, and subsequently the AMA and ANA boards of trustees, approved the recommendations developed by the task force. The recommendations are set forth in addendum A to this report. The thrust of the recommendations was to improve the health care of the aged chronically ill in terms of access and quality. To accomplish this, the task force recommendations focuse on learning more about how health care is being delivered to the aged chronically ill, investigating better alternatives, where necessary, and using the heatlh care professional team to its fullest advantage and potential.

Specifically, the Task Force recommended:
—Studies of new means to provide health care for the aged.
—Development and evaluation of alternative models of care.
—Development of public policy with respect to the care of the elderly, based on the best evidence available at the time; and
—Maintenance of the AMA-ANA liaison on health issues concerning the aged through an identifiable unit in each organization.

AMA DIRECTIONS

Current AMA activities, related to the aged are directed toward gathering and analyzing information. These activities cover such topics as disability among the aged, hospice care, the physiology of aging, and the nutritional status of the aged.

AMA activities currently in the planning stages focus on cooperative efforts with other health organizations interested in providing health care to the aged. These activities may include conferences and formal and informal liaisons with other national organizations. Other plans include studies of the effects of retirement on the aged, development of an aging "model," and investigation of alternative mechanisms to provide and to finance health care for the aged.

The board will make regular progress reports to the House on these and other AMA activities relating to the health and health care of the aged.

ACTION OF THE BOARD

In April 1983, the AMA board of trustees commended the members of the AMA-ANA task force for a thoughtful report. The board also approved the task force recommendations, and looks forward to their integration into the AMA policy activities in this report, aimed at improving the health and health care of the aged.

ADDENDUM A—MAJOR RECOMMENDATIONS OF THE AMA-ANA TASK FORCE TO ADDRESS THE IMPROVEMENT OF HEALTH CARE OF THE AGED CHRONICALLY ILL

1. That AMA and ANA jointly contact the National Institute on Aging of the National Institutes of Health to recommend funding the analysis of extensive research efforts on new health care systems for the aged. This analysis could be conducted most completely by such a body as the Institute of Medicine of the National Academy of Sciences.

2. That AMA and ANA fund the writing of a major research proposal to test other models of care, particularly as they involve cooperative physician/nurse relationships in community-based alternatives.

3. That AMA and ANA utilize their public relations capabilities to plead for time in the political arena—to retard the erratic forces which deny the scientific approach of study, analysis, experimentation and evaluation of long-term care models.

4. That the respective boards of AMA and ANA consider ways in which their organizations can develop the focal capacity to address the crucial health care issues of concern to the aged. Appropriate structures of the two associations should be mandated to maintain an active and ongoing relationship with each other in their work to improve the quality of health care for the older Americans.

Senator EVANS. Let us go back to Dr. Birnbaum. I think I have been struck all through the testimony this morning and certainly through the testimony of these last three witnesses with this puzzling, difficult tough question we are all going to have to face, and that is how we

provide adequate medical care, responsible medical care, within a cost we can really afford.

You say: We at Group Health in the Senior Caucus work to keep people in their homes, try to give them support, help them to change lifestyles, and wish for provisions in medicare and medicaid legislation to make these activities more affordable and more successful.

Can you provide for the committee some specific suggestions as to what provisions would be helpful to accomplish these goals?

Dr. BIRNBAUM. I touched on one of them, which is more emphasis on prevention and health promotion, health education, which is provided under Group Health coverage, to some extent, but is provided under the Group Health dues, not refundable by medicare or medicaid. In particular the so-called medigap insurance that nobody quite mentioned—and we are doing quite well on this. But a family of two, 65 or older, pays our medicare dues, which are close to $40 a person, plus $30 to medicare B, which means that the family has an outlay of $110. And that is cheap, if you look at other medigap insurances in the marketplace. And if preventive care were covered by medicare, we would have a much better handle on getting people into the prevention programs which we provide. And in the community, if prevention was part of the covered service, people would avail themselves of it.

As my neighbor here said, it is much cheaper to pay for prevention than for acute illness.

Senator EVANS. Perhaps we would have to ask this question of some of the leaders of either the health maintenance organizations or someone in the cost research field, but have you any ideas at all as to what extra cost might be involved in payment by medicare for a fairly substantial or comprehensive prevention system? How much might that add to the $110 a month this average family would pay?

Dr. BIRNBAUM. If medicare paid for it, in the short run, there may be an addition to cost. But in the long run, keeping people healthier would make it cheaper. For instance, the pneumonia vaccine that I mentioned before keeps people out of hospitals. It costs $4.50 and it is good for 6 years. A hospital today costs $350 or a little more.

So, prevention in the long run is cost saving. In the short run it may be an add-on. But you do not know exactly how many people you really keep out of the hospital with pneumonia, although it is known that seniors have pneumonia quite often.

Senator EVANS. It seems to me, from what I said in my opening remarks, that perhaps now is an urgent time to get at this question of long-term cost reduction through keeping people healthier because, for the next 10 or 12 years, we are not going to have a rapid increase in the number of people over 65; but after that, it is going to come pretty fast. And we had better be ready, and we had better have the kinds of systems that will do the job. Or we literally are going to be bankrupt not just in the medical system, but as the Federal Government. There are ominous signs ahead, unless we are able to do a smarter job than we have been able to do up to now.

Mrs. Jensen, you say that in your AARP legislative program that one of the elements was Government regulatory programs with potential to yield significant savings should be promoted along with effective measures to promote competition in the health care industry. Can you provide for us some of the proposed regulatory programs

that might be promoted? Does the organization have some specific suggestions along that line that would be helpful for the committee?

Mrs. JENSEN. I think along that line are wellness, prevention, and we think the Government should take a greater role in that. We think private industry has a responsibility here to promote health maintenance. And we think that all of us should work together along those lines. It is rather a simple thing, but it certainly has a broad perspective.

Senator EVANS. Maybe we should finance a wellness program through an extra tax on tobacco and alcohol.

Mrs. JENSEN. They are avoidable risks, I agree.

Senator EVANS. It might be a good idea. You also mentioned the proposal of Federal income tax credits for people staying within the family and within the family home. Do you have or does the organization have some suggestion as to what level of income tax credit might be required or appropriate to make that not only a good incentive, but to make it something that would work effectively?

Mrs. JENSEN. I am sorry to say I do not have any figures. I know that in Sweden they call this type of care given a treatment unit, and they allow moneys for it—maybe that is something we could use comparable figures with. I know also that family sometimes gets what we call burnout, and we feel that something along these lines would help stall that. They would not feel so overburdened. Respite care is another thing in here that we think is important.

I will try to get for you some figures along the line of what might be a reasonable, measurable income tax credit.

Senator EVANS. It would be helpful, because this is an idea I know has surfaced several times, and it should be pursued. You mentioned burnout, and I am sure that that is a problem. If a family had the extra benefit of an income tax credit that would result in that much more in the way of resources for the family, it would allow even some intermittent or relief care while that person is in the home, and it might be just the difference that would be very helpful.

One thing you mentioned which I know has been the subject of proposed legislation in the State of Washington—I suspect it has in other States and may well be the subject of national legislation, although I have not been around long enough to be aware of it—is the acquisition fever of nursing homes and hospitals and the revolving nature of ownership of some of these with an increasing cost basis and resulting higher depreciation costs. What specific suggestions would AARP have with that problem?

Mrs. JENSEN. We think that legislation should be passed to prohibit or limit them from this revolving or stepping up the value of their properties to reflect the purchase price. They get subsidies from the Government allowance for depreciation and interest at higher value. And this directly increases medicare payments for capital cost. So, I think there should be certainly oversight on this particular acquisition fever, as it has been named.

Senator EVANS. Of course, that happens with the sale of almost any piece of property. A building may have been built for a certain price. It is sold later for four times the initial price some years afterwards, and it sets a new depreciation schedule which results in increased rentals or benefits for the owners. Your suggestion is to select hospitals

and nursing homes out of that general authorization for stepping up of value?

Mrs. JENSEN. I think this definitely should be looked into. America's health cost industry is now No. 1. It used to be oil wells and then computers, and now it is the high-profit industry. And I think we have to look toward this, and I think that is a thrust we could make, we meaning Government.

Senator EVANS. Let me turn to Dr. Ambur with something that came out of Mrs. Jensen's testimony. Our system essentially rewards physicians, hospitals, health care providers with higher utilization in the form of more reimbursement. Do we need a change in that fundamental system which we have had for so long? Is there a real incentive to contain costs? You mentioned that physicians are in business to get patients well. I am sure that is true, and we all hope that that is the end result when we go to a physician. I am not sure that physicians have an opportunity to get as deeply involved in the preventative or the wellness kinds of services that should occur before anyone goes to a physician for a particular illness or problem. What about this idea that the health care cost crisis is the structure of the health care system itself. As the testimony points out, this system promotes inflation. It rewards doctors and hospitals with more and more income for providing more and more care.

Dr. AMBUR. I would say to a certain extent, the problem is not exactly the system, but it is in how it is paid for. The complete and total payment of costs up front encourages one to use the system to its maximum. And I have never been a believer in the 100-percent prepaid health care system unless you have a very well controlled lock-in model. And I notice the Group Health's testimony mentions the lock-in; the patients must receive their care from that one source. Otherwise I think both physicians and the patients must have some consideration and sit down and talk about the costs and what they are going to get for the money. That way you will get the best care at the most efficient price, but there are a lot of other variables in there that come up in the cost of health care. It has recently been estimated that up to 30 percent of the cost is defensive medicine. That has nothing to do with the health care system. That supports the legal system. So, that is another area of cost. The incentive, I think, if we changed the insurance, we will get a better, more efficient system.

Can I get to prevention?

Senator EVANS. Sure. Let me just interrupt for 1 minute. For the benefit of the audience who may not understand the practice of defensive medicine, do I understand correctly that you are talking about the requirement or the physicians' felt requirement that extra tests may be needed just to protect against lawsuits and other kinds of attack. Is that essentially what is at stake in your comment about practicing defensive medicine?

Dr. AMBUR. It is not so much to protect against the suit. If something goes wrong, you will frequently have a suit, but it is to have it all in paper at the time that you go before the lawyers. Let me give you an example too. If I do not dictate into my chart—and nobody would really think that dictation in your chart is something that costs money, but I have to pay somebody to do my typing and all that. I have to dictate many things that I would not ordinarily dictate because

it is assumed that if it is not dictated there, it was not done when you get to court. So, it doesn't seem like much, but it adds up. I get up and get dressed and go to work and do the same routine things everyday without dictating them into a diary, and I know I have done them. So, that is just a part of it. But, yes, it is there strictly for that reason.

On prevention, which we would like to talk about, I cannot believe in this day and age there is anybody left in this country that does not know or has not heard that smoking is bad for your health. I cannot believe that they have not been educated to that.

Senator EVANS. Talk to a Senator from a tobacco-growing State. [Laughter.]

Dr. AMBUR. Well, yes, that is true.

And seatbelts in your car, and yet only 14 or 15 percent of the people use them. Alcohol, weight control, all those things—I cannot believe that people do not know that that is the way they should live. And yet how many do that?

People do not really want to be saved until they have had their fun, and then you can save them later. I mean, if they really wanted to be saved, Prohibition would have worked.

Senator EVANS. It is called: Play now, pay later.

Dr. AMBUR. And it did not. I will just put it to you. We have got the costs of tobacco, alcohol, and entertainment equaling about 25 percent of the GNP. They are 15 percent ahead of the cost of health care. And that is what you are doing to repair the other problem.

Senator EVANS. You are right. While you are absolutely right and that seems to be a real imbalance, the difficulty we face is that a pretty good share of the health costs are paid directly through government at one level or another and through taxation, while the rest—the tobacco, alcohol, entertainment—are voluntary expenditures by individuals, and there is a marked difference in people's perception of paying taxes versus paying for pleasure. And that is why it is 25 percent and the other is probably 10 or 15.

If there were only some way to rebalance that whole system—you are right. This Nation has the financial capacity to provide not only adequately, but handsomely for our own wellness and for our own health. However, we have not been generated sufficiently as a total population to put our money in the right places.

I have no idea at this point how you can easily change that.

Mrs. JENSEN. Senator, we have some statistics: 19 billion in lost workdays due to alcoholism; $4.611 in cost to an employer for each smoking employee. And I think industry is going to get behind these and be more selective in their hiring. I noticed there was an article about that in the paper that would be of help.

On malpractice insurance. I wonder about the doctors policing their own group. Physicians' liability insurance reform target is excellent, but I feel too that the medical profession should work toward more effective procedures to make sure that intervention in case of malpractice winds up maybe in suspension or some form of punitive——

Dr. AMBUR. Are we getting into a debate? [Laughter.]

Mrs. JENSEN. I am sorry.

Senator EVANS. No. I do not think we had better get into a debate.

Dr. AMBUR. It is OK with me if it is OK with you.

Senator EVANS. No, that is at another time.

A couple of further questions for Dr. Ambur. You mentioned the renewed interest now in geriatric education. Are we really seeing a big response from young physicians or medical students, an increased real interest in geriatrics as a specialty that will prepare us for this future when we 10 or 15 years from now see this sudden surge of older people?

Dr. AMBUR. I think we certainly are, particularly right here in this State. We have one of the newest and most innovative and best teaching centers right up the hill here at Harbor View under the University of Washington. They have a geriatrics program. Of course the problems seem to come up before you think about getting a solution to it. So, they may be a few years behind in generating the people that are specifically trained in areas of geriatric medicine. But it is here, and this State has one of the best teaching institutions and one of the best continuing medical education programs out at the university to keep physicians aware of changes.

Senator EVANS. You mentioned in your testimony that initiative is needed to ensure the continuation of this and other geriatric centers which are threatened with extinction in the current cost-reduction trend. Where specifically is the cost reduction affecting those geriatric centers? Are those in special programs that are designed to aid geriatric centers?

Dr. AMBUR. Unfortunately the payment system under the DRG system that we have now, unless there is some flexibility that is put in, will penalize centers that are spending more money of course, which was the purpose of the DRG. But if you are going to do research and if you are going to learn something, you are going to have to spend a little bit of extra money to find out what you want to find out. And what we are concerned is that places like the university and Harbor View that are taking care of these problems and studying them will get lumped in and will not have the funds to continue on. People who are sick do cost money. The healthy ones do not cost money. But each individual is a little bit different. And that is the problem when you try to put an artificial cap on it.

Senator EVANS. I have one final question. Testimony earlier indicated that those who were members of a health maintenance organization used hospitals less on a per capita basis than those generally under a fee-for-service. I presume that is an accurate statistic. If it is, do you have any idea as to why?

Dr. AMBUR. I have my own ideas, yes. At least in comparing that to our particular county. In Kitsap County, I do not think it is exactly that accurate. Our day stay is pretty close to the closed panel model. Our total number of days per 1,000, per year, are very close. If you want to know why they would tend to treat it as, say, elective surgery, there are all sorts of ways you can treat arthritis of the hip. And you can try canes and medications, et cetera, et cetera, but we have learned that there is only one way to get rid of the pain, and that is to get a new hip joint. And if you wait 6 months or a year, you have saved the money over that period of time, as they do in England. Whereas if you come to see me and you have got an arthritis of the hip and you want it fixed, you get it fixed the next time we have an opportunity on the schedule. That is sort of the difference in the incentive.

Senator EVANS. This is a little off of any testimony, but some years ago I ran across some extensive statistics which pointed out the rather substantial difference in the average hospital stay for standardized kinds of procedures between various States and communities. I do not know if you have any comment or knowledge about that. But I remember at the time that for a simple uncomplicated appendectomy or for other rather common procedures, the hospital stay in the Northwest and particularly in the State of Washington was half that of some of the Northeastern States. What causes that?

Dr. AMBUR. That is true all across the board for medicare and the elderly population as well as the rest of them. I have not seen any specific studies as to exactly what causes it. One of the things that causes that difference is that in this State we do not have or did not have in the past the excess of hospital beds as compared to the east coast. Also western medicine grew up in a different atmosphere. The physicians out here in the bureaus are at risk. In other words, if there is not any money left, they do not get paid. They are the last ones that get paid, if you are a member of the county medical bureau. So, they have an incentive, just as the Group Health Cooperative does, to keep people out of the hospital unless it is an absolute necessity. So, it is different in other insurance programs where it makes no difference really to the physician whether they stay in the hospital or get out of the hospital. But here in the State of Washington it definitely does to all the physicians.

Senator EVANS. Would that have a significant impact if there were some way to spread that—I presume that you would suggest that while that incentive is to get out of the hospital, no physician would advocate that a person get out of the hospital any earlier than they were really able to, in terms of health. What way can we spread that same kind of result, or is it appropriate to try to spread that same result that we obtain out here to other parts of the country?

Dr. AMBUR. If you have in other parts of the country the type of insurance system that we have out here, the incentive is there. The Blue Cross insurance system in the rest of the country is not like our medical service bureaus and Washington Physician Service here.

The only other incentive to getting out of the hospital early is that the individual has to pay a certain amount themselves. I have my own theories as to how that should be handled. And I think if you wish to pay a certain amount for the hospital, you should say that the average day's stay for a knee operation is 3 days. If you are staying 5, unless there is a specific medical complication, you pay for it, because physicians do get put under the gun regularly. "I do not have a ride home today." "Nobody is there to take care of me." "We will pick grandma up on Monday, not today." That happens all the time. If the individual has an incentive to leave, the doctor is not going to let them out until he thinks they are ready.

Senator EVANS. Thank you very much. This has been a fascinating panel and a very interesting morning. I appreciate the testimony of all of those who have been scheduled and who have appeared in front of us. We are looking forward to the additional information we have requested. And this will be exceedingly helpful to the committee.

I might just explain to those in the audience that the Special Committee on Aging, like other special committees of the Senate, does not have legislation directly assigned to it as the Energy or Environment or other committees. But it is a committee which emphasizes the search for new solutions, and as such we can focus our efforts on looking to the future and developing new ideas and to creating legislation which can then go thorugh the regular procedure. I think that it is not only a healthy, but a very important kind of committee structure to have in the Senate, and I am delighted it is one that I am privileged to serve on.

A VOICE FROM AUDIENCE. I have one question.

Senator EVANS. Yes.

A VOICE FROM AUDIENCE. Given that committee structure, there is one woman's name on the committee. Many of the long-term elderly and other concerns highly involve women. How do women get on the committee?

Senator EVANS. You have to get elected to the Senate.

A VOICE FROM AUDIENCE. You must have some more women in the Senate.

Senator EVANS. There are two women serving in the Senate.

A VOICE FROM AUDIENCE. That says something right there.

Senator EVANS. Yes, it does. There are 98 men and 2 women in the Senate, which I think is inordinately tilted.

I might also say, just to speak a little politically before we quit, that they have often talked about a gender gap, but the two women in the Senate are two distinguished Republicans, I might say, Senator Hawkins from Florida and Senator Kassebaum from Kansas.

We have just a few minutes. If there are any comments from the audience, we would be able to take just a few very brief ones. I think we had better do it by having the panel retire. And then if you would come forward so that we can get your comments on the record, it would be helpful.

All right, good, we have got a panel of four. Go ahead and sit and be comfortable. And make sure you use one of those round mikes. If you could identify yourself and if there is an organization or a group you represent, do that and then tell us what you would like to.

STATEMENT OF REVA K. TWERSKY, SEATTLE, WA, MEMBER, SEATTLE-KING COUNTY ADVISORY COUNCIL ON AGING

Ms. TWERSKY. I am Reva Twersky, and I am a social worker who retired less than a year ago from over 15 years as a medical social worker at a teaching hospital. And I am on the Seattle-King County Advisory Council on Aging. I am chairperson of the subcommittee on long-term care of that organization. However, our committee would like to submit written testimony after our next meeting, if that is possible.

Senator EVANS. We would be most pleased to receive those comments.[1] That really acts as the base on which we can build our own ideas and our own new proposals. So, all of the comments this morning will be transcribed. They will be part of the record. And all of the written comments which we receive will be part of the same record.

[1] See appendix 1, item 7.

Ms. TWERSKY. It is well recognized that social, emotional, and environmental factors have an impact on a person's health and functioning. Therefore, I think that our system has been not to look at those important factors, but to expend large sums of money on acute care, which includes institutionalization. This has been highly inflationary, and health care costs have skyrocketed.

I want to speak in favor of allocation of funds for health services to States from the Federal Government in which funds for all long-term care services, including services provided in hospitals and by physicians to persons with long-term chronic conditions are pooled. States should be given prospective payments, based on good estimates of the frail population at risk of institutional placement. Such estimates should reflect accurate growth of the aged population each year. The prospective allocation should include a reasonable, planned inflation factor that is in line with the economy as a whole.

I view with great alarm reductions in medicare coverage which would result in increased out-of-pocket expenditures for consumers while health care industry costs are left uncontrolled. DRG's is an approach in the right direction, but will not work unless applied to the entire system rather than just hospitals.

I also want to state that the rapidly growing, better educated elderly population and their families will not tolerate reductions in needed services and funding as a means of containing cost. Something will have to change profoundly. Nickel-and-diming the system will not work.

Senator EVANS. Thank you very much. Next.

STATEMENT OF MARTHANNA E. VEBLEN, RETIREMENT COUNSELOR, SEATTLE, WA

Ms. VEBLEN. Perhaps I am coming from a little different perspective this morning than some that we have listened to. I am coming from a certain background of experience. I am a retirement counselor.

Senator EVANS. Could you identify yourself first?

Ms. VEBLEN. Excuse me. I should say I am Marthanna Veblen, and I am a retirement counselor, a librarian, and a research person.

As early as 1961, before I became elderly, I compiled the report of the State of Washington for the first White House Conference on Aging. This report was entitled, "Aging in the State of Washington," and it came out as a Senate document later.

In 1976, I published a directory of the services available in the State to the elderly, entitled, "Aging: Where To Turn in Washington State." And over the years I have served as a volunteer on State, county, city, and diocesan councils and commission concerned with the needs of elderly people. I am presently serving on the volunteer board of trustees of a private, nonprofit organization about to build a continuum of care retirement facility. Senator Evans would know the property. It is within a few blocks of where you once lived, sir. It is the Villa property.

A goal of the facility is to make one-third of the units available to low income elderly. In addition to this, on a personal level, my husband and I were very deeply involved with the aging process as it affected our parents while they were still alive. Both sets of parents celebrated their 60th wedding anniversary. From this background,

I put forward the following suggestions: that this U.S. Special Committee on Aging recommend Congress combine sections 231 and 232 of the Housing Act. Section 231 allows sponsors to provide meal service, and section 232 allows sponsors to provide intermediate and skilled nursing care. Combining these two sections will make possible the needed continuum of care retirement communities.

The second one would be: Congress authorize and appropriate adequate funds for the purpose of HUD guarantee of loans to provide financing of continuum of care facilities by private, nonprofit sponsors. Now, I am not sure of the year, but within the last 2 or 3 years, the amount authorized and appropriated by Congress would, if divided evenly between 50 States, not have provided for a single long-term care or continuum of care residence such as I am speaking of, that we are trying to build here in Seattle—not one in each of the States. And it is not a fabulously large one.

I recommend also that the Washington State Legislature, as a part of the package the State already has in place, authorize the use of tax-exempt bonds by private nonprofit organizations to finance continuum of care retirement communities.

I do feel the Federal Government should encourage Federal, State, and private nonprofit organizations to provide needed long-term services for the elderly at the lowest possible cost. By carrying out the three recommendations, we will be closer to satisfying the long-term needs of the elderly, particularly the moderate- and low-income elderly.

Services available in continuum of care retirement communities by private, nonprofit sponsors are rarely available elsewhere and then only at great cost, an amount usually beyond the reach of the moderate- or low-income elderly at a cost that can only be met by the affluent. Clearly, the three recommendations, if acted upon, will serve a valid public purpose.

Additionally, any emphasis by Congress by tax laws or otherwise, enhancing the savings ability of people in general, will encourage more saving and result in elderly persons entering retirement with more assets, thus improving their ability to live independently and with dignity.

And I really do appreciate the opportunity of being able to speak in this manner. And I have a copy of this for the record.

Senator EVANS. Yes, it would be very helpful if you would submit it, and it will be made part of the record. Thank you, Marthanna.

[Subsequent to the hearing, Ms. Veblen submitted the following information:]

The Honorable Daniel J. Evans
Senator, Washington State
Chairman, U.S.Senate Special Committee on Aging
RE: Long Term Needs of the Elderly: a Federal - State - Private Partnership.
Seattle, Washington
July 10, 1984

Senator Evans:

I appreciate the invitation to appear before you and this committee. It deals with a particularly critical area of need for the elderly. I have some thoughts on the topic and I am happy for the opportunity to express them.

I do feel that needed services to satisfy the long term needs of the elderly should be provided at the lowest possible cost to the elderly person. This should include continuing and expanding services which allow the elderly to remain as long as possible in their own homes.

I am coming from a certain background of experience: I am a Retirement Counsellor, a librarian and a research person. As early as 1961 - before I became elderly - I compiled the report of the State of Washington to the first White House Conference on Aging. This report was entitled Aging in the State of Washington. In 1976 I published a directory of services available in this state to the elderly entitled Aging - Where to Turn in Washington State. Over the years I have served as a volunteer on state, county, city and diocesan councils and commissions concerned with the needs of elderly people. I am presently serving on the volunteer board of trustees of a private non - profit organization about to build a continuum of care retirement facility. A goal of the facility is to make one - third of the units available to low income elderly. In addition, my husband and I were both deeply involved with the aging process as it affected our parents while they were still alive. Both sets of parents celebrated their 60th wedding anniversary.

From this background, I put forward the following suggestions:
That this U.S. Senate Special Committee on Aging recommend:

> Congress combine Sections 231 and 232 of the Housing Act. Section 231 allows sponsors to provide meal service, and Section 232 allows sponsors to provide intermediate and skilled nursing care. Combining these two sections will make possible the needed continuum of care retirement communities.

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(206) 524-9236

Congress authorize and appropriate adequate funds for the purpose of HUD guarantee of loans to provide financing of continuum of care facilities by private, non - profit sponsors.

The Washington State Legislature, as a part of the package the State already has in place, authorize the use of tax exempt bonds by private, non - profit organizations to finance continuum of care retirement communities.

I do feel the federal government should encourage federal, state and private, non - profit organizations to provide needed long term services for the elderly at the lowest possible cost. By carrying out the three recommendations above, we will be closer to satisfying the long term needs of the elderly, particularly the moderate and the low income elderly. Services available in continuum of care retirement communities, by private, non - profit sponsors are rarely available elsewhere, and then only at great cost, an amount usually beyond the reach of the moderate or low income elderly. A cost that can only be met by the affluent. Clearly, the three recommendations, if acted upon will serve a valid public purpose.

Additionally, any emphasis by Congress, by tax laws or otherwise, enhancing the savings ability of people in general ,will encourage more saving and result in elderly persons entering retirement with more assets, thus improving their ability to live independently and with dignity.

Thank you for inviting me to participate in this hearing. If I can answer any questions or help in any way in the future I would be happy to.

Marthanna E. Veblen

Marthanna E. Veblen
6640 Parkpoint Way N.E.
Seattle, Washington, 98115

July 10th, 1984

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STATEMENT OF LaVERNE GIRKE, SEATTLE, WA

Ms. GIRKE. Senator Evans, I am LaVerne Girke, a past president of the Washington State Retired Teachers Association, but I am just here more or less speaking as an individual. And I just wrote a few notes as this hearing was going on and some of the things that I came up with is that we all have to realize that we are our own preventative maintenance person. It is our responsibility to see to it that perhaps we do not get in some of those, although disease is no respecter of persons. I think there are many things that we can do, as suggested by the physician here, to keep ourselves healthy.

And you mentioned maybe using that alcohol tax money for some of these things, but it would not surprise me at all if we spend more money on rehabilitation for alcoholics than we do on some of the taxes we receive. I do not know what the amount of money would be.

Also I speak personally on taking care of the elderly. I have had in my home my father, who came with me last July. He was 93. He will be 94 in July. And I was surprised to find out when I called the income tax people, if I could deduct $1,000 of the $2,000 on my income tax for him; and I discovered at that particular time that although he is 94, he is only half the worth that anybody else is at age 65. After you are 65, you can deduct $2,000. However, at his 94 it is only $1,000. And I just wonder if you are aware of that and why it is that maybe this person at 94 can only have the $1,000 deduction.

Senator EVANS. No, I am not aware of that.

Ms. GIRKE. Another thing that I think might be looked into—my sister and I are shuffling dad back and forth, and I had him 6 months last year, and she had him 6 months last year. He has been here at my house now for a year. But when I called Internal Revenue, they said that you could only deduct the $1,000, and it had to be decided upon which one of you could take the $1,000. So, there is such a thing as a burnout when you are working with older people. And although I am very fortunate that my father is very healthy and is able to go and do things himself, although he is considered legally blind. He is not the responsibility that many elderly would be or could be. And if people have to shift maybe 6 months with John and 6 months with Sue, it might be helpful for those people to be able to have something on their income tax that they could reduce.

I was with a nurse not too long ago, and she was talking to me about some of the people in the nursing homes, and she said: One of the things that we have to do as a human being is to not—we must avoid learned helplessness. I think we do this for the elderly. And I think as a young person opens the door for us, we are very grateful. But if we would open the door ourselves and use our own muscles, we would be much more healthy for it. When dad first came, I just opened the door and shut the door and everything for him. But I have discovered although he hardly realized where he was when he first came—because my mother passed away and he had been with my mother for 62 years—letting him wipe the dishes and make his bed, even though it is not the greatest, and do some of the things, go in and out and open and shut the doors and things, we can keep these people more healthy if we let them have their exercise as much as their good food and so forth.

Senator EVANS. Thank you very much.

STATEMENT OF THELMA WISEMAN, SEATTLE, WA

Ms. WISEMAN. I thank you, Senator Evans, for allowing me to come up here. Let me introduce myself. My name is Thelma Wiseman. I am a social worker, and I am from the Graduate School of McGill University in Montreal, Canada. I know something about the Canadian system of helping the elderly. I am also from the Graduate School of the University of Michigan, Institute of Gerontology and School of Public Health.

From 1976 to 1980 I was employed for the long-term care and evaluation unit of the State of Michigan. During those years I saw approximately 1,000 persons each year through a six-county area covering Detroit. I had a good idea of what the frustrations, gaps, and insensibilities were in providing the needs of persons requiring long-term care. Here I would like to cite out of those thousands of persons only two examples, which would give you a very good idea of how we do not meet these needs.

The first example is that of an elderly black couple living in Ypsilanti, MI. The man is 90 years of age, the woman 85. The man has been admitted to a nursing home. The woman of 85, fairly spry for her age, is working as an aide in the same nursing home. When I go in there to review this situation, it does not make sense for the man to be in the nursing home while his wife can obviously take care of him. And, by the way, it is inappropriate in the nursing home for her to work the same floor where he is situated because it could cause an employee problem. Therefore, she is kept away from him during the day.

Michigan has a chore provider program. In 1979 when I visited this couple, the law stated that no wife could receive payment under the Chore Provider Program. This is an indigent couple living on their Social Security. The State prefers to keep this couple—the man in the nursing home and the wife working as a nurse's aide—rather than send them home and pay her as a chore provider.

A similar situation of a nurse's aide who fell in love with a paraplegic auto accident victim took place in Ann Arbor, was spread on the front page of the Ann Arbor News, and the State issued a waiver so that they could go home and not live without wedlock. But in this case I got nowhere.

I would like to cite one other case, and that is an example of private-pay elderly women who, because of widowhood, because of temporary illness, under stress or strain or whatever, nothing was mentioned in this whole 3 hours about mental health and the long-term care needs of mental health. And let me also mention that nothing was mentioned about—yes, it is less expensive, but nobody said more humane. These women enter nursing homes thinking they are there for a temporary time. Oftentimes temporary becomes 10 years. I come in, find that they are without any type of nursing needs but—there is a big "but"—by 10 years, these women who had money, no longer have anything left. And it is very hard, even though they are willing to do it mentally, it is very hard to move a person out into the community and set up support systems when they are without any assets whatsoever. And this happens time after time after time.

Thank you.

Senator EVANS. Thank you very much. This has been a very informative morning for me, and I am certain for those in the audience this will be helpful and, as I have expressed before, this hearing will represent some of the background we will use in the committee as we struggle with this task of providing a responsible health care system that is equally accessible to all citizens, with particular emphasis on the most rapidly growing portion of that health care system for the future, and that is the care of not only the rapidly growing elderly population, but an elderly population that is living longer, which is healthier generally, but collectively will eventually need some very special kinds of service.

So, thank you all for coming. Before we adjourn, I would like to make one introduction. I am happy to see Carolyn Preston in the audience. She served as a senior intern in our office this spring, and we were delighted to have her back there. And she will continue as not ony an adviser to my office, but as a strong advocate as she always has been in this particular field that we are talking about.

Ms. PRESTON. Thank you, Senator.

Senator EVANS. Thank you, Carolyn.

With that, the meeting is adjourned.

[Whereupon, at 12:39 p.m., the committee was adjourned.]

APPENDIXES

APPENDIX 1

MATERIAL SUBMITTED BY WITNESSES

ITEM 1. LETTER AND ENCLOSURE FROM DANIEL O. WAGSTER, SENIOR VICE PRESIDENT AND REGIONAL MANAGER, KAISER PERMANENTE HEALTH CARE PROGRAM, PORTLAND, OR, TO SENATOR DANIEL J. EVANS, DATED AUGUST 13, 1984

DEAR SENATOR EVANS: I appreciate the opportunity to appear before the Senate Special Committee on Aging hearing which you conducted in Seattle on July 10, 1984. I have sent to the committee office the corrected copy of my testimony on that occasion. Enclosed for your office is a copy of the written testimony that is to be included in the record.

In your introduction at the hearing you referred to the Kaiser-Permanente Oregon Region's Social HMO demonstration project. I do not feel that I adequately covered that subject in my testimony and, therefore, enclosed is a summary description of that project.

During the hearing you asked me to comment on section 1876 proposed regulations recently issued by HCFA. I responded by expressing our concern about certain aspects of the proposed regulations, but could not be specific because of time constraints. For your information, I am enclosing a copy of the written comments which our organization submitted to HCFA in that regard. We are pleased to be able to acquaint you and your committee with the nature and extent of our concerns with the regulations as proposed.

Thank you again for including Kaiser-Permanente among the organizations asked to provide testimony with regard to long-term needs of the elderly. We share with the committee interest in that important subject and we were proud to be able to report what our organization is doing about it.

Sincerely,

DANIEL O. WAGSTER.

Enclosure.

KAISER FOUNDATION HEALTH PLAN, INC.,
Oakland, CA, July 6, 1984.

Re BERC-247-P.
CAROLYNE K. DAVIS, PH.D.
Administrator, Health Care Financing Administration, Department of Health and Human Services, Baltimore, MD.

DEAR DR. DAVIS: Kaiser Foundation Health Plan, Inc. and its subsidiary Health Plan organizations ("Health Plan") submit the following comments on the proposed regulations regarding Medicare payment to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs"). The proposed regulations were published in the Federal Register, May 25, 1984, beginning at page 22198. The Kaiser-Permanente Medical Care Program ("Program"), of which Health Plan is an integral part, is the nation's largest organized private health care delivery system. It consists of seven nonprofit federally qualified health maintenance organizations, currently serving more than 4.5 million members including approximately 270,000 Medicare members in ten states and the District of Columbia. The Program has long been an advocate for establishing the prospective payment mechanism that is the subject of these regulations. We are pleased that the regulations will be adopted in the near future.

The preamble to the proposed regulations asks for comments on a number of important issues. Comments were requested on requiring eligible organizations to have a coordinated pen enrollment. Since the regulations were published, Congress has required coordinated open enrollment as part of this program. We have a number of concerns about the implementation of this requirement, and strongly recommend that it be the subject of a separate notice of proposed rulemaking. This will permit adequate evaluation and the development of specific comments on the implementing regulation.

Comments also were requested concerning the possible applicability of the prompt payment provisions in 31 U.S.C. 3901–3906 to the monthly payments made to eligible organizations. These provisions allow for the collection of interest payments by an entity in the event of failure by the government to make prompt payment under certain contracts. We support the application of these provisions to prospective payment contracts with HMOs and CMPs. We strongly support provisions of section 417.584 which require HCFA to make monthly advance payments to the HMO for each beneficiary who is registered in HCFA's records as a Medicare enrollee of the organization. It would be HFCA's failure to make these advance payments according to its contract with an HMO or CMP that could trigger the interest provisions of 31 U.S.C. 3901–3906.

The proposed regulations note that HCFA is reasonably satisfied with the current method of calculating the adjusted average per capita cost ("AAPCC"). We strongly urge HCFA to refine the AAPCC methodology by adding a disability status adjuster in the final regulations as suggested in the preamble to the regulations. We also encourage HCFA to expend significant effort on advancing the state of the art in this area so as to improve the AAPCC methodology.

While we believe that implementation of this prospective payment program should begin using the existing AAPCC with the refinement noted above, we recommend that HCFA establish a Risk Contract Advisory Committee composed of actuarial experts, statisticians, researchers, and representatives of risk contractors. The purpose of this committee would be to advise HCFA about methods to improve the AAPCC. We believe there are a number of areas for exploration. As program data and experience increase, periodic changes to improve the factors used to estimate population risk (i.e., age, sex, institutional status, Medicaid eligibility) should be considered. We commend the proposed use of Medicare Disability status. Social Security Disability status for those age 63 or 64 could be an important additional risk factor, particularly for those persons just enrolling as Medicare aged. If access to this SSA information requires a change in the law, then this change should be sought. Other federally certified disability statuses should also be explored as measures of risk (e.g., veterans, black lung, etc.)

Those persons age 65 or over who are employed and have private health benefits will no longer be covered by Medicare. Historically, these persons have been very low users of Medicare benefits and HCFA should consider revising the existing risk values by omitting such persons. The probable net effect will be to diminish the disparity between persons (particularly males) age 65–69 and older beneficiaries, since employment is disproportionately higher in this age group than at older ages.

We continue to believe that work force participation prior to age 65 is important to examine. It is an objective and well documented enrollee attribute that can be of considerable value in measuring health status after age 65.

We recommend that HCFA publish as a companion to these regulations a monograph on the AAPCC. This would describe how the methodology works, how the risk or actuarial factors were determined, how the data is used in the methodology and its sources, and other relevant factors that would be helpful in developing a better understanding among HMOs, CMPs, and others about the methodology.

We recommend that HCFA provide to each risk contractor adequate information and data for it to calculate its AAPCC. Since this payment methodology is central to the implementation of these proposed regulations, the payment amounts need to be verifiable by the contracting organization. This also would allow an HMO or CMP to make more accurate projections, which are important for financial planning.

The preamble also states that HCFA is interested in the possibility of using the AAPCC as an overall limit on the payments made during a contract period to HMOs and CMPs with cost contracts. We strongly oppose this suggestion because it would subject HMOs and CMPs to standards that they either rejected or were ineligible to choose, and would, in effect, change the cost based reimbursement that is available to other organizations, such as those with HCPP

contracts under Section 1833 of the Social Security Act. Moreover, such a restriction would be particularly unfair to small HMOs and CMPs, which during their initial development stages might have greater costs per capita than the AAPCC for an area.

Finally, we support HCFA's decision to permit organizations with risk contracts to obtain an administrative hearing regarding determinations of the amount of program reimbursement they will receive. Administrative hearings and appeals should be available to HMOs and CMPs on the same basis as other providers.

The following comments are addressed to specific sections of the proposed regulations.

1. Section 417.401 includes a definition of the AAPCC. The AAPCC is defined as an actuarial estimate which ". . . represents what the average per capita cost to the Medicare program would be for each class of the organization's Medicare enrollees if they had received covered services other than through the organization in the same geographic area or in a similar area." The preample to the regulations on page 22208 indicates that the cost of all eligible organizations in the same or similar geographic area would be excluded in determining the AAPCC for the area. Section 417.588 also supports the exclusion of costs of all eligible organizations. The intent of the statute is that the AAPCC should represent only the equivalent average fee-for-service cost for Medicare beneficiaries in an area. This is the method used to determine the AAPCC for current Section 1876 risk contracts, and the 1982 amendments to the statute did not alter this. Section 417.401 should be modified to exclude from the AAPCC all costs relating to eligible organizations in the area.

2. Section 417.401 defines geographic area to mean ". . . the area found by HCFA to be the area within which the organization furnishes, or arranges for furnishing, the full range of services that it offers to its Medicare enrollees." The HMO should establish its service area. We recommend that this definition be modified to read: "Geographic area means the area proposed by the eligible organization and approved by HCFA. . ."

3. Section 417.401 provides a definition of urgently needed services. The definition should be modified to require that such services are needed because of an unforeseen health problem or one that was not reasonably postponable. The modification would preclude coverage when individuals who need surgery or other treatment voluntarily leave the organization's service area to obtain services from non-plan providers. The supplementary information section of the proposed regulations discusses the standard for financial responsibility for services furnished outside the organization, explaining that emergency and urgently needed services are those immediately required because of an unforeseen illness, injury or condition. To assure that this intent is met in the regulations, we suggest the definition of urgently needed services be amended to state ". . . means covered services that are not postponable and are required for an unforeseen illness, injury or condition in order to prevent serious deterioration of an enrollee's health when he or she . . ."

4. Subsection 417.413(b)(4) provides that a subdivision or subsidiary of an organization need not meet the membership requirements, (e.g., at least 5,000 enrollees) as an independent unit if the organization of which it is a part assumes responsibility for the financial risk and adequate management and supervision of health care furnished by its subdivision or subsidiary. We strongly support this provision because it will assist in the development and growth of small HMOs associated with large HMOs without financial risk to the Medicare beneficiary.

5. Subsection 417.413(e) requires an organization to provide annual open enrollment periods of at least 30 days during which Medicare beneficiaries are enrolled on a first-come, first-served basis to the limit of the organization's capacity. It is important that an HMO be permitted to establish reasonable capacity limitations for all or parts of its service area, so that new Medicare enrollees can be properly served. We support the flexibility permitted in this section and section 417.426 concerning the determination of capacity limitations. It is appropriate that this determination be based on the unique circumstance of each HMO or CMP.

6. Subsection 417.413(e)(2) defines enrollment as being "substantially nonrepresentative" ". . . if the proportion of a subgroup to the total enrollment exceeded, by 10 percent or more, its proportion of the population in the organization's geographic area, . . ." This definition conflicts with the definition in sub-

section 417.424(b) which sets as a standard "exceeds by at least ten percentage points its proportion to the general population in the geographic area of the organization." These provisions should be consistent. Section 417.424(b) should be amended to specify the percentage as "by 10 percent or more."

7. Section 417.420 sets forth the basic rules on enrollment and entitlement. We recommend that this section allow an HMO or CMP to provide members who age into Medicare the option of enrolling under either a risk or cost contract. This would permit an organization to allow a member to enroll without a lock-in if this was desirable.

8. Subsection 417.420(d) requires Medicare enrollees of an organization that has contracted on a risk basis to be responsible for services received outside the organization, other than emergency and urgently needed services, if the services should have been furnished by the organization. This subsection should be clarified to limit this requirement to Medicare enrollees under a risk contract or to enrollees under a cost contract who have agreed to lock-in provisions. Many large HMO's will have a substantial number of Medicare enrollees who will remain under cost contracts with no lock-in provisions until they can be converted to risk contracts. As currently stated, it appears that all Medicare enrollees of an organization with a risk contract would be subject to the lock-in rules.

9. Subsection 417.426(c) provides that an organization may set aside a reasonable number of vacancies "for an anticipated new group contract that will have its enrollment period after the Medicare open enrollment period . . ." This provision should be broadened and made consistent with language in the preamble of the regulations on page 22203, to include anticipated growth in existing group contracts as well as new group contracts. The organization should also be able to reserve vacancies for anticipated enrollment in groups that precede the Medicare open enrollment period. We recommend that subsection 417.426(c) be amended to read: "An organization may set aside a reasonable number of vacancies for anticipated new group contracts and other group contracts that will have their enrollment periods during the contract year."

10. Subsection 417.428(a)(2) requires the organization to submit all brochures relating to marketing and promotional and informational material to HCFA for approval. It further provides that if HCFA does not respond within 60 days of receipt of the material, "the organization can assume approval." We believe 60 days is far too long a period for HMOs and CMPs to adequately carry out marketing efforts or to make needed changes in materials on short notice. We recommend that the 60-day period be changed to 10 working days. In addition, the regulations should state that the materials "will be deemed approved", rather than "can assume approval."

11. Subsection 417.428(b) describes prohibited marketing activities. Given the potential for abuse, we recommend that this section be amended to prohibit door-to-door solicitation. Given the experience in the early 1970's with prepaid health plans in California, we are concerned about marketing abuses.

12. Subsection 417.432(b)(1)(i) requires an organization to notify HCFA at least 90 days before an enrollee attains the age of 65 if the enrollee is to be included as a Medicare enrollee. We suggest that this time frame be shortened to 45 days since many prospective Medicare enrollees may not be ready to make a choice so far in advance. Numerous enrollees do not apply for Medicare until the month prior to age 65. As a result, HCFA will not have a record of Medicare eligibility and the accretion request will be returned to the HMO, thereby increasing unnecessary information exchange.

13. Subsection 417.432(b)(1)(ii) requires the organization to notify HCFA at least 90 days before an enrollee reaches his or her 25th month of entitlement to social security or railroad retirement disability benefits. Frequently an HMO would not have information to enable it to comply with this requirement. We recommend that the provision be deleted.

14. Subsection 417.422(b) provides that individuals who have end-stage renal disease are not eligible to enroll under a risk contract. Section 417.434, however, implies that ESRD members of organizations before they enter into risk contracts and enrollees who acquire ESRD after enrolling, must be allowed to continue membership unless they are disenrolled under section 417.460. Proposed regulations, however, do not specify the method of payment to a risk organization for ESRD Medicare eligibles. We recommend adding a subsection to section 417.588 which defines a separate rate for individuals in the ESRD category. We also recommend that the AAPCC calculation for ESRD services reflect a rate based on metropolitan statistical area, census region or other geographic area

where ESRD services are provided. -This will reflect Medicare expenditures for these services more accurately than an enrollee's State of residence.

15. Subsection 417.444(c)(6) requires a plan to restrict enrollees from receiving payment directly or on their behalf for covered items and services received from sources outside the organization. It may be difficult or impossible for a plan to carry out this responsibility. Often a plan will have no way of knowing if its enrollees use out of plan services. Usually the only time that a plan will know this is when the enrollee submits a claim for reimbursement. It is more appropriate for HCFA to assume this responsibility, since it will be the paying entity from whom payment is requested. We recommend that HCFA annotate its membership files in such a manner that payment for these enrollees can be made only to the HMO or CMP.

16. Subsection 417.452(c)(3) requires that "the sum of the amounts an organization charges its Medicare enrollees for services that are not covered under Part A or Part B may not exceed the ACR for these services." If this paragraph is applied to payment for Part A services for enrollees who are entitled to Medicare Part B only, an HMO or CMP will be deprived of its full financial requirements for the member. This results from the fact that the AAPCC will usually be greater than an organization's ACR for Part A services, since an HMO's major cost savings is in reduced hospitalization. The opposite is true for Part B services. There the ACR will usually be larger than the AAPCC because of the emphasis placed on ambulatory services by the HMO. Subsection 417.440(b) states that Medicare enrollees who are entitled to Medicare Part B only are entitled to all services covered under that part. The regulations do not appropriately address how the Part B only Medicare enrollees pay for Part A services under a risk contract.

To correct this serious problem, we recommend that subsection 417.452(c)(3) be amended by adding to the first sentence the language, "except in the case of a member entitled to Medicare Part B only, in which case the organization can charge a premium that will permit the organization to receive a total amount for Medicare Part A and B services which equals 95 percent of the AAPCC for that member."

17. Subsection 417.448(b)(2) provides that the Medicare member who moves from the organization's geographic area is no longer locked-in and may receive Medicare covered services from any provider. However, if the member has not been disenrolled by the organization and the organization continues to be reimbursed for the member, the organization must accept responsibility for reimbursing all Medicare covered out-of-plan care. Subsection 417.460(a)(2) prohibits an organization from disenrolling a member who moves out of its service area unless it "establishes, on the basis of a written statement from the enrollee or other evidence acceptable to HCFA, that the enrollee has permanently moved out of its geographic area" and has given the enrollee written notice of termination before it sends termination t. HCFA. To make these sections consistent we recommend that subsection 417.448(b)(2) be amended to read "Medicare enrollees who permanently leave the geographic area served by the risk organization as of the first day of the first month after an enrollee provides written notification to the organization that he or she has permanently moved out of the area. This would make the termination of the lock-in consistent with the termination of HCFA's liability to make monthly payments to the HMO on the enrollee's behalf.

18. Section 417.458 requires an organization with a reasonable cost contract to recoup deductibles and coinsurance amounts for which Medicare enrollees were liable under a previous contract only under certain conditions. This provision should be clarified to assure that these amounts can be accounted for through an adjustment of future premiums and that such an adjustment may be made on a group as opposed to an individual basis.

19. Subsection 417.460(a)(2) requires disenrollment when an enrollee has permanently moved out of the organization's service area, since it will then be impractical for the HMO to provide services to the enrollee as contemplated under a risk contract. There are no provisions, however, for individuals who split residency between two separate geographic areas. This is common for elderly people especially those living in colder climates. They will not have moved permanently, but will be out of the organization's area for an extended period, usually longer than would be considered temporary. In this case, we propose that the regulations allow an enrollee who is leaving a residence in the organization's geographic area for more than 90 days, but who plans to return

no later than six months from departure, to disenroll under subsection 417.460 (a)(2) and to reenroll under section 417.426. This would enable these enrollees to reenroll immediately and not be subject to subsection 417.426(a)(2) (which provides for enrollment in the order in which the applications are received). Subsection 417.426(a)(3) should be amended to read "The organization may accept applications after it has reached capacity if it places those individuals on a waiting list and enrolls them in chronological order as vacancies occur, except that an organization may immediately reenroll an individual who within the last six months was disenrolled from the organization upon leaving the geographic area pursuant to subsection 417.460(a)(2) and at the time of reenrollment is living in the service area."

20. Subsection 417.460(a)(1) allows disenrollment for failure to pay premiums, but does not provide a basis for disenrolling an enrollee who fails to establish and maintain a satisfactory physician-patient relationship within the plan. An organization should be permitted to disenroll such individuals, since neither the member nor the plan are likely to find this situation desirable or conducive to the provision of quality medical care.

21. Subsection 417.492(a)(1)(i) requires that the organization provide written notice to HCFA at least 90 days before the end of the contract period if it does not intend to renew the contract. Subsection 417.584(b)(2) provides that HCFA must provide the AAPCC 90 days before the beginning of a contract year. This time frame would not permit an organization to review the adequacy of the AAPCC in order to decide whether or not to renew the contract. Subsection 417.584(b)(2) should be amended to provide that HCFA will furnish the AAPCC 180 days before the beginning of the contract year as recommended in our comment 24.

22. We strongly oppose the provisions in subsection 417.532(a)(3). HCFA should not use the adjusted average per capita cost as a general limit for reimbursement to a reasonable cost organization as stated in our introductory comments.

23. Subsections 417.560(c) and (d) address payment for emergency services and other covered Medicare services for which the organization assumes financial responsibility and precludes payment if the charge is greater than the reasonable charge. We recommend that this section include the provisions of 42 CRF 405.2043(c)(3) which sets forth a more reasonable requirement. That section allows the justification of a greater amount by stating ". . . payment of the charges of a physician or other Part B supplier rather than reasonable charge for the service defined in Subpart E of this part may be justified if: The physician or other Part B supplier furnishes services to enrollees of an HMO on an infrequent basis, such charges represent an insignificant amount of total reimbursement to the HMO by the program; and such charges do not exceed the amounts charged by such physician or other Part B supplier to other patients for similar services." In cases when payment for such services is infrequent and an insignificant part of total reimbursement, it would not be reasonable to expect an HMO to determine reasonable charge rates for the various geographic areas to which its Medicare members travel.

24. Subsection 417.584(b)(2) provides that HCFA will furnish each organization with its per capital rate of payment (AAPCC) no later than 90 days before the beginning of the organization's contract year. Subsection 417.592(d) requires the organization to notify HCFA no later than 45 days before the beginning of the contract period of its adjusted community rate. We believe that the proposed time frames are inadequate. We recommend that the AAPCC for the next contract period be provided to an HMO or CMP at least 180 days before the end of the current contract period, and that the HMO or CMP provide its adjusted community rate to HCFA at least 120 days before the end of the current contract period, and that HCFA make a decision on the adequacy of that rate within 30 days of its receipt or the rate is deemed approved. These time frames are necessary in order to allow an HMO adequate time to prepare its marketing and enrollment activities prior to the beginning of a contract period. Ninety days are necessary for this process, particularly in the initial years of a risk contract. The proposed 90-day time period for HCFA's provision of the AAPCC to HMOs and CMPs is inconsistent with subsection 417.442(a)(1)(i) of the proposed regulations which provides that an HMO or CMP must give at least 90 days notice of cancellation of a contract. Clearly, the 90-day time frame for the AAPCC does not allow adequate time for evaluation and cancellation of the risk contract if an HMO finds the AAPCC to be inadequate.

25. Section 417.588 sets forth the method of computing the AAPCC. It specifies the basis for the U.S. per capita incurred cost and geographic adjustments. We recommend that the regulations specify the method for projecting these costs into the contract year, including the methods of forecasting inflationary increases that will be used to establish the AAPCC. We also urge that prior to implementation the AAPCC be modified to include a disability status adjusted as noted in the preamble to the regulations.

26. As noted in our introductory comments, we recommend that the regulations require HCFA to provide each risk contractor adequate information and data for it to calculate its AAPCC. Since this payment methodology is central to the implementation of this program, an HMO or CMP should be able to verify the payment amount, as well as make more accurate projections for financial planning purposes.

27. We also recommend that HCFA publish, as a companion to these regulations, a monograph on the AAPCC. This would describe how the methodology works, how the risk or actuarial factors were determined, how the data is used and its sources, and other relevant factors that would be helpful in developing a better understanding among HMOs, CMPs and others about the methodology.

28. Subsection 417.594(c)(2)(i) ". . . allows the organization to make an adjustment to its community rate to reflect the differences in the complexity or intensity of services furnished to its Medicare enrollees if the adjustment is made equally to *all* enrollees." Subsection 417.594(c)(2)(ii) contains a similar provision. Normally an organization would analyze the complexity and intensity of services to two groups, those under 65 and those over 65. The requirement of subsection 417.594(c)(2) (i) and (ii) that the adjustment be made equally to "all enrollees" and "all enrollees and nonenrolled patients of the organization" should be deleted or changed to read "all Medicare enrollees." Without this change, the requirements could be constdued to mean experience rating for non-Medicare enrollees which is prohibited under the Title XIII of the Public Health Service Act.

29. Subsection 417.594(e)(2) provides that the HMO may request a hearing if it is dissatisfied with HCFA's determination of the organization's ACR. This provision should be extended to include the AAPCC because it also affects the payment rate.

30. In the case of organizations which compute the ACR using the initial rate calculation described in subsection 417.594(b)(3), we recommend that item (ix) Overhead, be eliminated as a separate component of this calculation. It should be allocated among direct service components as is the current common practice. Overhead is driven by and a function of the direct service components.

31. Subsection 417.594(c) sets forth adjustment factors to the ACR but refers only to unit of service and complexity or intensity of services. The prospective payment system applicable to hospital providers results in a cost per unit that may be more or less than the organization's cost from a related provider or charges from an unrelated provider for non-Medicare enrollees. This cost differential should be recognized by the regulations as an appropriate measure of intensity for purposes of adjusting the initial rate. Such a cost differential would be recognized by an organization in developing an ACR for inpatient services provided to enrollees eligible only for Part 8 coverage.

32. Risk organizations that receive reimbursement for current non-risk Medicare enrollees are paid on a reasonable cost basis (417.524(b)). In the case of HMOs or CMPs who own and operate hospitals, it is not clear if Part A payment will be made under the Prospective Payment System (PPS). We recommend that the regulations specify that Part A payments to HMOs and CMPs for care in hospitals owned or under common control with the HMO or CMP be made under PPS for reasonable cost enrollees in an 1876 contract.

33. The risk regulations do not take into considerable the complexities of group vs. individual enrollments. Subsection 417.452(a)(2) allows another organization to pay deductible and coinsurance amounts on behalf of an enrollee. However, subsection 417.592(b)(1) might indicate that reductions in premiums accrue directly to the Medicare enrollee. If the premium reduction cannot be paid directly to the organization or group that paid the premium on behalf of enrollees, risk organizations which have group enrollees aging into Medicare eligibility for risk membership and have their premiums paid by the group will have severe difficulties with group enrollment. In group contracts, HMOs contract with the group and not the individual enrollee in the group. If an HMO with a risk contract has difficulty enrolling a group's Medicare enrollees, the overall contract between the group and the HMO could be jeopardized. Since the proposed rules

do not specifically address group related issue, they leave several unanswered questions. Group members usually age into Medicare eligibility. Can groups who pay premiums on behalf of their Medicare members receive reductions in premiums? Can reductions in premiums be paid in cash?

We recommend that the final regulations provide that groups which pay premiums on behalf of group enrollees may receive the reduction in premiums and/or that the savings be returned to the enrollee in the form of cash. We also question whether a group can make a decision which forces their Medicare employees or retirees to accept a risk contract.

34. We understand that an organization with an approved risk contract can continue to receive reimbursement for its nonrisk Medicare enrollees through HCPP contracts under Section 1833 of the Social Security Act. We recommend that the regulations be clearly amended to clearly set forth this option.

35. The proposed regulations should be amended to address the special problems raised by federal annuitants.

36. Some individuals who attain age 65, retire and qualify for Medicare, subsequently return to employment. If such individuals age 65 through 69 are enrolled in a risk organization under Medicare, they would lose eligibility when they return to work if they elect their employer's coverage as primary and Medicare as secondary. This situation could result in enrollment/disenrollment problems, particularly if individuals frequently change their employment/retirement status. The proposed regulations should be amended to cover these problems.

We recommend that risk contract enrollees who return to employment retain enrollee status as inactive members during their period of employment, but not be counted for payment or capacity purposes. These individuals could reactivate membership upon retirement or attaining age 70 and should be counted as "ageing" under the 2 for 1 enrollment criteria. This process would reduce administrative problems of enrollment, disenrollment and reenrollment.

37. These proposed regulations do not address payment for hospice services under a risk contract. We recommend that the proposed regulations be amended to cover this subject.

38. Finally, we note Congressional passage of the Deficit Reduction Act of 1984, which in Section 2350 authorizes the use of a benefit stabilization fund and expands the type of providers to whom Medicare can make direct payments for HMO services. We strongly recommend that provisions related to these two provisions be included in the final regulations. As noted in our introductory comments, that because of the difficulty associated with the implementation of the requirement for coordinated open enrollment also included in this Act, we recommend that it be the subject of a separate notice of proposed rulemaking.

We appreciate the opportunity to provide these comments and would be pleased to discuss the issues raised and to answer any questions.

Very truly yours,

KAISER FOUNDATION HEALTH PLAN, INC.,
(By) ROBERT M. CRANE, *Vice President—Government Relations.*

ITEM 2

Kaiser-Permanente's Medicare Plus Project: A Successful Medicare Prospective Payment Demonstration

by Merwyn R. Greenlick, Sara J. Lamb, Theodore M. Carpenter, Jr., Thomas S. Fischer, Sylvia D. Marks, and William J. Cooper

The Medicare Plus project of the Oregon Region Kaiser-Permanente Medical Care Program was designed as a model for prospective payment to increase Health Maintenance Organization (HMO) participation in the Medicare program. The project demonstrated that it is possible to design a prospective payment system that costs the Medicare program less than services purchased in the community from fee-for-service providers; would provide appropriate payment to the HMO; and in addition, creates a "savings" to return to beneficiaries in the form of comprehensive benefits to motivate them to enroll in the HMO.

Medicare Plus was highly successful in recruiting 5,500 new and 1,800 conversion members into the demonstration, through use of a media campaign, a recruitment brochure, and a telephone information center. Members recruited were a representative age and geographic cross section of the senior citizen population in the Portland, Oregon metropolitan area.

Utilization of inpatient services by Medicare Plus members in the first full year (1981) was 1679 days per thousand members and decreased to 1607 in the second full year (1982). New members made an average of eight visits per year to ambulatory care facilities.

Editor's Note

In September 1982 the Health Care Financing Administration (HCFA) awarded contracts to 21 organizations for development and implementation of Medicare competition demonstrations in which alternative health plans will contract with HCFA at prospective capitation amounts and market benefit packages to Medicare beneficiaries in their service areas. This article describes one of five HCFA-funded contracts to develop and test Health Maintenance Organization (HMO) models under prospective capitated reimbursement. The demonstrations were described in the *Health Care Financing Review*, Volume 3, Number 3, March 1982.

HCFA is funding an independent evaluation of the Kaiser project as well as four others now in the operational phase of their contracts. As the evaluations progress, reports on research findings from the HMO demonstrations will be published in future issues of the *Review*.

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To older Americans, the traditional health care system is a vital but bewildering array of medical specialties, hospitals, nursing homes, claim forms and unplanned expenses. No one can erase the physical, psychological and economic problems imposed by advancing age. But the medical care system can move to deal more equitably and effectively with the health problems which place such heavy burdens on older Americans. (Iglehart and Lane)

This paper describes a project which attempts to deal more equitably and effectively with the health problems of older people. The Medicare prospective payment demonstration project (known as Medicare Plus) of the Oregon Region Kaiser-Permanente Medical Care Program (KPMCP) is one of several Medicare experiments funded by the Health Care Financing Ad-

ministration (HCFA). The project's goal is to increase HMO participation in the Medicare program by designing and implementing a model for prospective payment that would allow Medicare members of an HMO to have prepaid benefits similar to HMO younger members. Such a project should:

1. Cost the Medicare program less than services purchased in the community from fee-for-service providers.
2. Provide appropriate payment to the KPMCP, based on an adjustment of its community rate.
3. Provide a savings to return to beneficiaries as a means of motivating them to enroll in the project and accept the KPMCP as their sole provider of nonemergency medical services.

A basic component of current national health policy is to encourage the development and growth of health maintenance organizations as a cost-effective alternative to the fee-for-service health care delivery system. To that end, it has been proposed that HMOs increase their participation in the Medicare and Medicaid programs. However, to make this attractive to group practice HMOs, it was necessary that Medicare and Medicaid be changed to include HMO operating provisions.

An awareness of the extent to which reimbursement formulas can affect costs and the failure of retrospective cost reimbursement to embody cost consciousness in the delivery of services led to the advocacy of prospective payment under Medicare. This, in turn, led to the development of the Health Care Financing Administration's (HCFA) experimental program in this area,[1] and to the inclusion of prospective payment legislation in the 1982 Tax Equity and Responsibility Act (TEFRA).

Sufficient incentive is needed for Medicare beneficiaries to enroll in HMOs because to do so may mean changing providers and possibly having less freedom of choice of physicians and hospitals.

The Medicare Plus project tests the extent to which this can be accomplished by paying HMOs a meaningful portion of the savings resulting from their efficiency, which then can be passed on to their Medicare members in the form of added benefits, lower rates, or both. This requires HCFA to pay HMOs more than their adjusted community rates for providing Medicare covered services, but will result in HMO members receiving greater benefits than other Medicare beneficiaries. Although this is contrary to the way Medicare has operated previously, it is essential if HMO participation in Medicare is to be increased. Incentives for enrollment in cost-effective systems are a basic requirement for significant delivery system reform. It is economically sound to reward prudent purchasers of health care services.

There are a number of methods for paying HMOs, two principles are essential for the active participation of HMOs on a risk basis:

1. The rate should be determined prospectively on a *per capita* basis. Both the HMO and the Medicare program should know what the rate will be in advance to allow effective planning and budgeting.
2. The rate should include the savings which an HMO creates through its operational efficiencies when compared to non-HMO costs in the area.

The initial rate setting involves a trade-off between maximum expansion of Medicare membership in HMO's (by including all or most of the savings in the rate) and minimum short-term costs to the Medicare program.

The KPMCP, which is the largest prepaid group practice plan in the United States, has had extensive experience in providing care to Medicare and Medicaid beneficiaries and in participating in the development of Federal and State regulations concerning HMOs. Included among the 4.2 million persons covered in the nine regions of the program are 251,000 Medicare members.

The KPMCP receives payment for Part A (hospitalization) services on a retrospective cost basis using standard Medicare reimbursement rules. Part B payments are based on retrospective cost determination in accordance with the group practice prepayment plan provision of the Medicare Act. KPMCP Medicare members enroll in a supplemental plan which covers the deductible and coinsurance amounts not covered by Medicare and provides selected optional services, such as preventive health services, which Medicare does not cover. Thus, Medicare does not pay the KPMCP a prospectively determined rate, which is the usual way in which an HMO receives payment; nor does the KPMCP have any contracts under Section 1876 of the Act (the Medicare HMO provision).

Although the KPMCP's total Medicare membership is substantial compared to the total size of most HMOs, it is only about 6 percent of the KPMCP's total membership and most Medicare members were members of the Health Plan before they became entitled to Medicare.

The KPMCP has not made substantial efforts to enroll Medicare beneficiaries who are not already members for the following reasons:

1. The benefit or rate incentives to join are inadequate or uncertain.
2. The existing payment provisions (SS1815, 1833, and 1876) are retroactive, which is inconsistent with the KPMCP's basic method of operation.
3. The "lock-in" requirements of Section 1876 are considered difficult, if not impossible, to impose upon existing Medicare beneficiaries who are not currently so restricted.

The KPMCP is able to provide more benefits or lower rates than other insurers because it assures appropriate use of services, especially hospital services. Members use substantially fewer hospital days per thousand persons than comparable fee-for-service

[1] This project was performed under RFP HCFA-78-OPPR-22/PHG.

*Erratum: Oregon's 65+ hospital rates were 2,901 days per 1,000 in 1978; 4,121 days per 1,000, the number which appeared in the publication, is actually the national rate for 1976.

populations. In 1978, before this project began, Oregon Region members were hospitalized at the rate of 384 days per 1,000 persons enrolled in the program. This contrasts with the national rate in 1978 of 1,225 days per 1,000 persons. For the population age 65 and over, the rates were 1,630 days per 1,000 for KPMCP members in Oregon contrasted with ~~4,121~~* days per 1,000 for the State's aged population (1978).

A similar situation in utilization exists in the Medicare program. KPMCP Medicare members use substantially fewer days than Medicare beneficiaries who obtain services from fee-for-service providers (see Table 1). However, under existing Medicare reimbursement provisions, all savings accrue to the Medicare Trust Fund and not to Medicare beneficiaries. Tables 2 and 3 compare the utilization rates of hospital days and doctor's office visits of members within the Oregon Region who are under age 65 with the rates of members age 65 and over.

TABLE 1

Hospital Days per 1,000 Persons Age 65 and Over

	KFHP, NCR	United States	Age/Sex Adjusted KFHP Rates (Assuming U.S. Age, Sex Population Distribution)
Pre-Medicare[1]	2,322	3,449	2,453
After Medicare[2]			
1967	2,189	3,698	2,912[3]
1968	2,269	3,990	2,552
1969	2,154	4,048	2,336
1970	2,019	3,904	2,193
1971	1,989	3,835	2,190
1972	1,989	3,835	2,225
1973	1,990	3,853	2,171
1974	1,797	3,963	1,918
1975	1,858	4,003	2,030
1976	1,791	4,121	1,945
1977	1,677	4,156	1,906
1978	1,660	4,184	1,884
1979	1,640	4,182	1,851

[1]Data are for the two latest pre-Medicare periods for which such information is available; the year ended June 30, 1963 for KFHP, Northern California, and calendar year 1965 for the US (Source: PHS Publication No. 1000, Series 13, No. 3).

[2]Utilization data through 1976 for the U.S. general population age 65 and over are from mid-monthly "Hospital Indicators" sections of *Hospitals*. (Source for 1977, 1978, and 1979: *Health United States* 1979, 1980, and 1981 issues; DHHS publications No. (PHS) 80-1232, (PHS) 81-1232 and (PHS) 82-1232.) Average population figures used to convert total hospital days to rates per 1,000 were estimates of the resident civilian population as of July 1 of each year. Source: Selected issues of US Department of Commerce *Current Population Reports*.

[3]The 1967 hospital day rate is age-adjusted only. Hospital days by male-female distributions are not available.

TABLE 2

Inpatient Days per 1,000 Health Plan (Oregon Region) Members

	Younger Than 65 Years	65 Years and Over	Total Health Plan Members
1966	427	1,690	516
1967[1]	388	1,505	473
1968[1]	355	1,313	428
1969	399	1,643	487
1970	371	1,533	449
1971	361	1,572	440
1972	348	1,630	408
1973	329	1,604	405
1974	310	1,679	392
1975	327	1,684	411
1976	309	1,653	396
1977	303	1,707	396
1978	296	1,630	384
1979	300	1,776	399
1980[2]	278	1,651	381
1981	262	1,557	382
1982	273	1,607	401

[1]An experimental extended care facility was in operation at Bess Kaiser Hospital and artificially reduced utilization.

[2]The Medicare Plus project began enrollment in August 1980.

TABLE 3

Doctor Office Visits per 1,000 Health Plan (Oregon Region) Members

	Younger Than 65 Years	65 Years and Over[1]	Total Health Plan Members
1966			3,369
1967	3,279	4,769	3,392
1968	3,192	4,741	3,316
1969	3,104	4,550	3,207
1970	3,280	4,566	3,366
1971	3,307	4,639	3,393
1972	2,981	4,411	3,067
1973	3,015	4,414	3,100
1974	3,136	4,846	3,243
1975	3,043	4,968	3,165
1976	2,995	4,899	3,123
1977	2,915	4,907	3,051
1978	2,761	4,660	2,891
1979	2,567	4,629	2,711
1980[2]	2,546	4,964	2,734
1981	2,559	4,889	2,783
1982	2,555	5,189	2,817

[1]Includes under 65 Medicare disabled.

[2]The Medicare Plus Project began enrollment in August 1980.

38-441 O - 84 - 7

Project Design

The specific objectives of the Medicare Plus project, were to develop, implement, and evaluate:

1. A prospective payment system for Medicare members of the Oregon Region of the KPMCP;
2. A system for enrolling the new Medicare members;
3. A service and benefit experiment to test the factors influencing enrollment.

The project design encompasses the essential features of the experimental capitation model outlined by HCFA in the original call for proposals:

1. It is consistent with principles of prepayment.
2. It provides appropriate revenue to the HMO.
3. It is administratively manageable.
4. It provides savings to the Federal government.
5. It promotes the efficient delivery of health services.
6. It has incentives for beneficiaries to enroll.
7. It promotes quality of care.
8. It provides comprehensive health care services.
9. It allows freedom of choice.

Prospective Payment System

Under this experiment, the KPMCP receives payment from HCFA at the beginning of each month for each Medicare Plus member. The payment includes KPMCP's adjusted community rate for Medicare covered services (ACR), and the savings which provide additional benefits. The ACR covers all Medicare A and B services and is adjusted to reflect differences in benefits, utilization rates, and the effective date of the rate and time/complexity factors required to provide services for Medicare enrollees compared to other enrollees of the Health Plan. This ACR is all that KPMCP receives for Medicare covered services. In addition to the ACR, the monthly payment covers all standard Medicare supplemental benefits, plus payment for special new member services. These additional benefits and services are provided from the "savings," the difference between the ACR and 95 percent of what Medicare calculates it would pay for these beneficiaries in the fee-for-service system (the average adjusted *per capita* cost or AAPCC).

Each year a rate of payment is calculated for the coming year. This calculation requires the following four steps.

1. Calculate the rates comprising the "AAPCC ratebook."

HCFA's Office of Financial and Actuarial Analysis computes a single rate for each cell of a "ratebook." There is a cell for each single category of person, characterized by age, sex, county of residence, welfare status, and institutional status. For example, there is a rate for a woman, between age 85 and 89 living in county "A," not on welfare, but living in an institution. There is a rate for a man, younger than age 65 but disabled, living in county "B," on welfare, but not living in an institution. The rate in each cell is 95 percent of the projected average *per capita* cost of non-HMO Medicare beneficiaries in that cell.

2. Forecast population distribution.

This step involves forecasting the percentage distribution of aged and disabled Medicare beneficiaries to be enrolled in the next year in each cell of the "overall ratebook." This was a particular problem for the first year of the project since the distribution to be enrolled was unknown. For the first year (1980), existing KPMCP Medicare membership distributions were used to project age, sex, and county distributions. Welfare membership was projected to be zero and institutionalized membership was estimated to be 0.5 percent. These were conservative estimates since the actual membership was expected to approximate the characteristics of the Medicare beneficiaries of the community, a somewhat older population than the Oregon KPMCP's. The actual characteristics of the Medicare Plus enrolled population were used for projections in subsequent years.

3. Calculate composite monthly capitation rates.

This step involves taking a weighted average of the rates to yield a single rate of payment, using the population distributions from Step 2.

4. Recalculate rates of payment retroactively.

While the rates calculated in Step 1 are totally prospective, the actual population distribution for each year is used in a final adjustment. If different population characteristics yield a different actual rate of payment, adjustments are made as noted below.

Developing the adjusted community rate (ACR) each year requires the following steps.

1. Compute a program-wide community rate (CR).

The community rate is the per member, per month revenue required to provide prepaid health care services to enrolled members.

2. Disaggregate the CR into specific components.

The total forecasted CR is separated into major components of Part A and Part B services and is apportioned to the Medicare cost categories in a manner consistent with current Medicare reimbursement guidelines.

3. Develop adjustment factors.

Two types of adjustment factors are necessary to properly reflect the varying cost of providing services to specific populations—volume factors and time and complexity factors. Volume factors reflect different use rates for the various components by the specific population. The time and complexity adjustment takes into account variations in the amount of time

and resources necessary to provide a given volume of services to different populations. These are calculated for both hospital and medical services.

Table 4 summarizes the ACR and AAPCC calculations for 1980-1983. In 1980 the difference between these two amounts, that is, the difference between 95 percent of Medicare's average adjusted *per capita* cost (AAPCC) and the Oregon KPMCP's adjusted community rate (ACR), was $19.71 per month. In 1981 the savings was $19.38, $16.76 in 1982, and $26.76 in 1983. This "savings" is returned to the beneficiary as a "reward" for selecting a more efficient medical care program. Under Medicare Plus, the first priority for use of the savings is to pay for Medicare supplemental coverage.

TABLE 4

Summary of Payment Calculation/Combined Aged and Disabled

	1980	1981	1982	1983
95% of Average Adjusted Per Capita Cost (AAPCC)	97.90	113.65	139.65	165.44
Adjusted Community Rate (ACR)	78.19	94.27	122.89	138.68
Savings	19.71	19.38	16.76	26.76
New Member Entry	1.15	1.15	.50	1.00
Benefit Stabilization Fund	3.38	1.10	<2.17>	1.02
Available to Offset Medicare Supplemental Coverage	15.18	17.13	18.43	24.74
Medicare Supplemental Dues	15.18	17.13	23.43	27.74
Required Member Contribution	.00	.00	5.00	3.00

Before this experiment, all Medicare members in the Health Plan were responsible for a monthly premium to cover the cost of Health Plan covered services not included under Medicare and of Medicare deductibles and coinsurance. The Medicare supplemental coverage (M-plan) was developed in order to provide aged KPMCP members the same benefits and access to the program as younger members. In addition to paying M-plan dues, the experiment enhances but does not significantly change the care received by Medicare Plus members and provides some new services. The amount allocated for these new services in the first two years was $1.15 per member, per month.

Any portion of the savings which is not required for current benefit and service packages is retained by HCFA in a benefit stabilization fund (BSF) to smooth out year-to-year variations which are caused by calculating the AAPCC and ACR independently of each other and making annual retroactive adjustments for variances between actual and forecasted demographics. At the end of 1980, the BSF contained $118,616; of this, $77,293 derived from the 1980 payment formula and $41,323 from the retroactive demographic adjustment. This fund grew to $315,000 by year end 1981, and was drawn on in 1982 to moderate the rate increase.

Benefits Experiment

A major purpose of the benefits experiment was to explore the extent to which the KPMCP could attract new Medicare enrollees. These new enrollees would have to give up their previous methods of receiving medical care and agree to receive all their medical services through the KPMCP, except in an emergency. This obviously would be a profound change for some older people, especially if they were satisfied with the medical care they were receiving.

To encourage them to join an HMO, Medicare beneficiaries were offered a variety of health benefits not covered by Medicare. All project enrollees received Medicare supplemental coverage with dues paid from the savings generated by this demonstration. Some Medicare beneficiaries, however, were also offered optional benefits for small additional dues. The experiment was intended to explore which new health benefits or combination of benefits were most effective in recruiting new Medicare members.

Persons applying during the first two months of enrollment were randomly assigned to one of two experiment groups. Half were offered only Medicare supplemental coverage (M-plan) for no monthly cost, while half were offered a choice of the M-plan alone (at no cost) or the M-plan plus the chance to purchase one of three optional benefit packages (see Figure 1).

Randomization was determined by the social security number for new applicants and by the Health Plan identification number for conversion applicants. Families were randomized as a unit based on the first number provided; thus, husband and wife were offered the same coverage options.

Marketing Plan

The marketing plan to recruit 4,000 members began with a two-week media campaign designed to ensure that all Medicare beneficiaries in the service area would be invited to join the project during the six-month open enrollment period. Marketing material also emphasized the need for each individual to weigh the advantages and disadvantages of enrolling based on his/her individual situation and requirements for care.

Television announcements ran in 95 spots (60 or 30 seconds) on all four local commercial stations. They were shown about six times a day during popular viewing times for senior citizens. The television announcement was successful in reaching a very high proportion of the area's senior citizens.

MEDICARE PLUS
OPTIONS - CHOOSE ONE ☑

Your Monthly Cost $0 ☐

COMPREHENSIVE MEDICAL CARE BENEFITS including

For No Charge:

Complete hospital services (inpatient and outpatient) including all physicians' and surgeons' services in a Kaiser-Permanente facility.

All laboratory services, X-ray tests and therapy, casts and dressings.

Prescribed home health and homemakers' services.

Up to 100 days per year or per spell of illness (whichever is greater) in an approved skilled nursing facility.

For $2 per Visit at Kaiser-Permanente Facilities:

All physicians' services and medical office visits.

Preventive health care services, including physical examination and most immunizations.

All emergency care.

Physical therapy.

Vision and hearing examinations.

Other:

Reimbursement for medical care services for emergency or unexpected conditions when you are either traveling out of the Portland-Vancouver service area or are unable to come to a Kaiser-Permanente facility because of your medical condition.

Mental health services: Psychiatrists—$2 each outpatient visit (limit 6 per year); other professionals—$2 each outpatient visit (no limit). Inpatient psychiatric services for no charge (190 day lifetime limit).

All other Medicare covered services, such as ambulance, prosthetic devices, and durable medical equipment.

HEALTH CARE FINANCING REVIEW/Summer 1983/Volume 4, Number 4

Your Monthly Cost $6 ☐

COMPREHENSIVE BENEFITS + DRUGS, EYEGLASSES, AND HEARING AIDS, including

- All benefits on page 4.
- **Each prescription** (or 30-day supply) for $1, when ordered by a Kaiser-Permanente physician and obtained at a Kaiser-Permanente pharmacy.
- **Hearing aids**, at no charge, when prescribed and obtained at Kaiser-Permanente facilities.
- **Eyeglasses**, lenses and frames (from a specified selection) at no charge when prescribed and obtained at Kaiser-Permanente facilities.

Your Monthly Cost $9.81 ☐

COMPREHENSIVE BENEFITS + DENTAL CARE, including

- All benefits on page 4.
- **Total dental care**, including examinations, cleaning of teeth, fillings, dentures and other prosthetic devices at no charge when prescribed and obtained at Kaiser-Permanente dental facilities.

Your Monthly Cost $15.81 ☐

COMPREHENSIVE BENEFITS + DRUGS, EYEGLASSES, AND HEARING AID COVERAGE + DENTAL CARE, including

- All the benefits described on page 4 and in the two options above on this page.

96

A newspaper announcement including a mail-in coupon and a telephone number appeared 20 times in major local papers and several specialty publications. The media campaign was supplemented before and after by regular contacts with a network of public and private agencies serving the elderly.

The major focus of the marketing plan was to encourage interested Medicare beneficiaries to request information about Medicare Plus. Applications and brochures explaining the program were sent to those who did so. Considerable effort went into developing a recruitment brochure that clearly explained the complexities of the project and outlined the eligibility requirements, the advantages and limitations of joining the program, and the procedures for enrolling.

Care was taken to fully inform potential enrollees of the unique features of the demonstration, such as the need to obtain all services through KPMCP (thus giving up Medicare payment for services performed by other providers). Potential enrollees were informed that the program was subject to change and that they must maintain their Part B coverage. The brochure pages describing the program's limitations are shown in Figure 2 to illustrate how the wording, use of type, and layout contribute to communicating clearly with potential enrollees.

Second Marketing Campaign

The initial target enrollment of 4,000 was assured in July 1980, two months after beginning of marketing. At that time the enrollment limit was raised to 5,500 and a second marketing campaign began to enroll 1,500 additional members by the end of the year. This campaign featured 77 television announcements, a limited number of newspaper announcements, and a news release to about 60 local senior citizen agencies. An inquiry letter was sent to persons who had indicated interest during the first campaign but had not yet applied.

Telephone Center

When enrollment began, a Medicare Plus telephone center was opened in KPMCP administrative offices. Temporary employees staffing the center were given a two-day orientation program and a reference manual so they would provide consistent information to callers. Telephone response was so heavy during the first week of the media campaign that it became necessary to hire and train three additional operators and to add three phone lines to the existing six. A recording device was installed to take messages after working hours. The telephone center remained open for seven months to respond to enrollment requests and to coordinate the enrollment process and new member mailings.

To provide personal assistance to applicants, assistance desks were set up at a number of local senior centers and at KPMCP facilities throughout the metropolitan area.

Conversion Members

The conversion of existing Health Plan members to Medicare Plus was limited in order for Medicare to achieve a net savings on this demonstration. Under the demonstration contract, which is based on what HCFA calculates it would pay for services in the fee-for-service system, HCFA would pay more for an existing Medicare Health Plan member under Medicare Plus than under existing law. Therefore, KPMCP agreed to convert only one Health Plan member for each three new members enrolled.

Brochures and applications were mailed to all 9,000 nongroup Medicare Health Plan members. From the 3,000 who responded, 1,500 were randomly selected and 300 more were put on a waiting list. These 300 additional applicants were accepted when it was assured that new member enrollment would reach 5,500.

A small number of Health Plan members complained about the conversion limitation because they were treated less favorably than new members. Most accepted the explanation that the conversion limitation was necessary to achieve the goal of the demonstration, that is, to change Federal legislation to allow all Medicare beneficiaries the option of receiving medical care on a prepayment basis.

Other Marketing Activities

Due to the success of the television campaign, other marketing activities were very limited. A letter with a tear-off return postcard was sent to 40,000 Health Plan members under age 65 asking them to inform their friends and relatives about Medicare Plus. This was done after the media campaign. Approximately 1 percent responded. During the six-month open enrollment period, a speaker's bureau was maintained and presentations were made to all groups who requested them. In a special effort to reach low-income groups, recruitment material was distributed to all public housing locations and speakers were sent to several public housing meetings. The eight AAA senior citizen centers in the metropolitan area served as information and referral points.

Marketing Campaign Results

The media campaign generated requests for about 15,000 information packets. Those requesting packets were representative of the senior citizens living in the area in terms of county of residence and age (see Table 5). Over two-thirds of the inquiries were made by telephone; most of the remainder came from the mail-in coupons.

IS THIS SPECIAL PROGRAM REALLY FOR YOU?

Some Limitations

Before you join **MEDICARE PLUS**, you should review carefully this important information about the program.

- ☐ This program may not be advantageous to you if you live outside the Portland-Vancouver area for many months each year.
- ☐ By joining **MEDICARE PLUS**, you agree to receive all of your health care services through Kaiser-Permanente facilities, physicians, and staff. Neither Medicare nor **MEDICARE PLUS** will pay for care received from other providers except for an emergency in which you could not reasonably be expected to get to a Kaiser-Permanente facility because of your medical condition. **Currently you do not have this limitation for Medicare covered services.**
- ☐ You will be joining a large, possibly unfamiliar health care program and you will need to learn your way around this system.
- ☐ You must maintain your Part B Medicare coverage.

- ☐ The **MEDICARE PLUS** program is subject to change:

  Benefits could change somewhat during the program. There is also the possibility that you may have to pay a small monthly charge for **MEDICARE PLUS** benefits in 1981 or 1982.

  The program ends on December 31, 1982.

  At the end of the program, you will still have your Medicare benefits. You may choose to remain a member of the Kaiser Foundation Health Plan and convert to the standard Medicare coordinated coverage (which does not include prepaid prescription drugs, hearing aids, eyeglasses, and dental care), but you may have to pay for it yourself. This coverage now costs about $15 a month.
- ☐ Professional liability or hospital liability claims exceeding $500 for bodily injury, mental disturbance, or death must be submitted to binding arbitration.
- ☐ While you may drop out of **MEDICARE PLUS** at any time, with 30 days notice, you may not be able to rejoin later. However, you may choose to remain a member of the Kaiser Foundation Health Plan and convert to the standard Medicare coordinated coverage but you may have to pay for it yourself.

TABLE 5

Marketing Information Requests, by Age of Requestor[1]

Number	Percent	Age
415	7.0%	Under 65
1851	31.3	65-69
1535	25.9	70-74
1135	19.2	75-79
620	10.5	80-84
270	4.5	85-89
72	1.2	90-94
17	0.3	95-99
6	0.1	100 or more
5921	100.0%	

[1]Includes packets requested through October 31, 1980. Those with unknown age (2692) were excluded.

Approximately 49 percent of the information packets mailed by September 28 resulted in one or more applications being returned for enrollment by October 31. The application response rate was about the same for each of the five-year age categories over age 65 and for urban and rural areas of the five-county area. The response rate was highest (about 52 percent) for telphone requests; mail-in coupons had a response rate of about 39 percent (see Table 6).

The marketing campaign was effective in notifying the eligible participants and in attracting people who were likely to enroll. It was also successful in attracting a representative age and geographic cross section of the senior citizen population. This is a significant finding since some people in the Federal government were concerned that only a limited and special subgroup of the aged population would be invited to join the program.

TABLE 6

Percent of Packets Returned by Source of Request

Percent Returned	Source
51.9%	Telephone or Walk-in
39.2%	Newspaper Coupons
44.3%	Staff Presentation
27.0%	Mail-Out to Under 65 Members
47.6%	TOTAL

(n = 7506 requests)

Enrollment Results

The media campaign obtained an impressive response, resulting in 3,500 enrollment request cards submitted to HCFA in June and July, 1980. From these requests, about 2,000 new members were enrolled for August 1 coverage and 1,400 for September 1 coverage. For the remainder of the year, new member enrollment leveled off at 500-600 each month; the target 5,500 membership was reached on January 1, 1981 and a high of 5,886 was reached on March 1, 1981. Applications received after enrollment closed on November 30, 1980 were placed on a waiting list and none of these applications was processed until August 1981 when death and cancellation experience reduced the new membership. Conversion membership reached a high of 1,904 for February 1, 1981 coverage. Table 7 shows year-end membership flow.

A total of 655 members died or requested termination during the first coverage year for a termination rate of 7.9 percent. About one-third of these cancellations resulted from death of the member.

TABLE 7

Medicare Plus Year-End Membership, 1980-1982

	1980			1981			1982		
	New	Conversion	Total	New	Conversion	Total	New	Conversion	Total
Base (only)	2414	800	3214	1581	563	2144	1953	678	2631
Base + SB[1]	1588	403	1991	2404	714	3118	2447	592	3039
Base + DNT R[2]	106	14	120	132	35	167	86	24	110
Base + DNT R + SB	997	334	1331	1557	543	2100	1339	462	1801
TOTAL	5105	1551	6656	5674	1855	7529	5825	1756	7581

[1]Special Benefits consist of prescription drugs, vision and hearing aids.
[2]DNT R—Dental Benefit

Population Characteristics of Enrollees

The population enrolled is somewhat older than the Health Plan's existing over age 65 membership (see Table 8 for comparison of Health Plan and Portland populations). One-sixth of the new members are over 80 years of age and three members are over 100 years of age. The male/female distribution is 40/60 for members aged 65-80 and 35/65 for members over age 80. The proportion of disabled enrollees (4 percent) is similar to the proportion of disabled members in the Health Plan's Medicare population. The enrollment results indicate that a representative age and geographical cross section of the senior citizen population was enrolled. The 5,500 new members represent 4 percent of the eligible population in the five-county enrollment area. This new enrollment brought the KPMCP's proportion up to 17 percent of the total over age 65 population in the market area served by the Health Plan.

TABLE 8

Medicare Plus Comparative Age Distribution

Age Group		Medicare Plus	KFHP 65+ (Less Med Plus)	Portland & Salem SMSA B.P.A. Est.
65-69:	Male	13.7	19.6	15.3
	Female	19.5	21.9	19.0
	Total	33.2%	41.5%	34.3%
70-74:	Male	12.2	12.4	11.4
	Female	17.1	14.5	15.4
	Total	29.3%	26.9%	26.8%
75-79:	Male	8.3	6.6	7.3
	Female	12.0	9.4	11.3
	Total	20.3%	16.0%	18.6%
80-84:	Male	4.1	3.4	4.5
	Female	6.9	6.3	8.0
	Total	11.0%	9.7%	12.5%
85+	Male	2.1	1.9	2.6
	Female	4.1	4.0	5.2
	Total	6.2%	5.9%	7.8%
TOTAL		100.0%	100.0%	100.0%

Benefit Experiment Results

There was no statistically significant difference in the proportion of applications returned by those offered basic Medicare Plus *at no charge* (49 percent) and those offered an additional opportunity to purchase one of three optional benefit packages (47 percent). The experimental randomization was discontinued after two months and, early in 1981, all Medicare Plus members were given a chance to add, drop, or change optional benefits with the result that over 70 percent of members enrolled in one of the three extra packages.

New Member Entry Program

The special services and materials developed for this population were designed to ensure the effective transition of Medicare Plus members into this large, relatively complex program. The new member entry program included a member handbook, a health information form, special reserved appointment procedures, telephone informational tapes, member newsletters, medical office open houses, and, most critically, a Medicare Plus representative. The program was financed during the first year by $1.15 per member per month from the savings.

A key component of the program was the Medicare Plus representative, who played an important role in the development of the new member entry program and in staff orientation. The major functions of the representative were to direct new member orientation, to serve as health care coordinator and ombudsman for project enrollees, and to inform KPMCP operating personnel about the special services, benefits, and circumstances of project enrollees. During the beginning of the project, this office handled at least 1,000 inquiries each month.

A Medicare Plus Member Handbook, designed especially for this population, contained step-by-step information on how to use services (including a contact guide which told the new member what to do to obtain specific services such as medical advice). Information about benefits, doctor appointments, physical examinations, prescription refills, or emergency service was also included. The handbook was written in easy-to-read language and was designed using large print (see Figure 3). A service guide, including physicians' names, a list of facilities and telephone numbers, a map of facilities, and other material, was also produced to assist new members.

A health information form was created to obtain current health status information from members and to identify chronic conditions which might need immediate medical attention. The form was designed using large print with a few simple questions to encourage a high response rate; more than 90 percent were completed and returned. A physician reviewed the forms and the Medicare Plus representative made appointments, if necessary. Appointments were reserved on the schedules of primary care providers for Medicare Plus members who required immediate care or who were anxious to establish a patient-doctor relationship. In addition, project team members designed a protocol for KPMCP pharmacies to make it easier for Medicare Plus members to obtain necessary prescription refills during this transition period.

Recorded telephone tapes gave information similar to that provided in the new member handbook, and telephone numbers for the six tapes were listed in the handbook as well as on a printed card sent to the member's home. Bi-monthly newsletters were published to reinforce information about KPMCP services and Medicare Plus coverage and to provide a means

CONTACT GUIDE

	YOUR NEED	WHAT TO DO
1	**MEDICAL ADVICE** You don't feel well but are not sure whether you need to see the doctor or You need advice about a medical problem.	Phone any one of the MEDICAL ADVICE NUMBERS listed on pages 12-14 and Have your Health Plan Identification card handy.
2	**BENEFITS/"HOW TO"/QUESTIONS** You're not sure whether you are covered for the service needed or You don't know how to "use the system" or You need help selecting a doctor.	Refer to the Health Plan Service Agreement or Phone the taped telephone message numbers listed on the inside back cover or Phone your **MEDICARE PLUS** REPRESENTATIVE at 224-PLUS
3	**DOCTOR'S APPOINTMENT** You feel sick or You want your new doctor to take over treatment of your diabetes, high blood pressure, etc. or You want to become acquainted with your new doctor.	Select a FAMILY PRACTICE or INTERNAL MEDICINE physician at a conveniently located medical office and phone the APPOINTMENT NUMBER for an appointment. (See pages 12-14 for telephone numbers and additional information.)
4	**PHYSICAL EXAMINATION** You feel fine, but have not had a physical exam for 18 months or more.	Call the Health Appraisal Center at 777-4611. Tell the appointment clerk you are a new **MEDICARE PLUS** member and would like a physical or Select a personal Kaiser-Permanente physician and make an appointment with him. (See page 4 for more information.)
5	**PRESCRIPTION REFILL** You feel fine, but need a new supply of necessary medicines.	Call the Pharmacy at a conveniently located Kaiser-Permanente medical office. (See pages 17-18 for more information.)
6	**EMERGENCY**	Go to the nearest hospital Emergency Room or call 285-9321 or 653-4411. (See page 15.)

of communication for the Medicare Plus representative.

Assisted by medical office staff, the Medicare Plus representative conducted 15 open houses at various KPMCP facilities. New members were invited to have their questions answered and to learn how to use the medical office of their choice, how to make an appointment, how to get a prescription, and where service departments are located. Approximately 10 percent of new members attended (a considerably higher response than is generally achieved for this type of orientation of Health Plan members).

Utilization

Medicare Plus members used hospital beds at a rate of about 1,677 days per 1,000 members per year during the first 12 months of service (Table 9). This rate is slightly higher than that of other over age 65 members, but it is approximately what was predicted for this population. For comparison, the use rate in this age group in the Portland SMSA in 1978 was 3,142 days per 1,000 people per year, according to data from the Oregon State Health Planning Agency

On the other hand, the annualized utilization rate for office visits per 1,000 members is somewhat higher than for other Medicare members and is also somewhat higher than predicted. The data for 1980-1932 are given in Table 10.

The number of visits for this population seems to be relatively stable; therefore, this population may require somewhat more ambulatory care than was predicted (Table 10). This, of course, has implications for both cost and organization of care. For example, early data indicate that estimates of prescription utilization for Medicare Plus members with a prepaid prescription benefit are also too low. This caused a significant increase in the prescription prepayment rate for 1982. Skilled nursing facility utilization was initially lower than predicted and this pattern has continued.

TABLE 10

Medicare Plus
Outpatient Utilization

	Visits per 1000 members, per year		
	Medicare Plus	Other Medicare	Percent Medicare Plus Higher
1980			
Physician	5875	4752	24
Nonphysician	2303	1568	47
TOTAL	8178	6320	29
1981			
Physician	5762	4513	26
Nonphysician	2009	1553	28
TOTAL	7771	6063	27
1982			
Physician	5780	4914	17
Nonphysician	2010	1521	32
TOTAL	7790	6462	21

Assessment of the determinants of this utilization pattern has begun and various hypotheses are being offered. One hypothesis that must be considered is that the barriers of the existing Medicare system produced a significant amount of unmet need that has become manifest when these barriers were removed. Another hypothesis is that people who are more likely to select an HMO are those with a higher propensity to use services. It is possible that utilization may be reduced after people become more familiar with the system.

TABLE 9

Medicare Plus
Hospital Utilization by Discharge Days

	Kaiser Foundation Hospitals	Supplemental Beds	Nonemergency Claims	Total Hospital Days	Mean Member Months
1980[1] days	2148	157	577	2882	1904[1]
Days per 1000 per year	1128	83	303	1514	
1981 days	12034	266	299	12599	7505
Days per 1000 per year	1603	35	40	1679	
1982 days	11987	40	—0—	12027	7484
Days per 1000 per year	1602	5	—0—	1607	

[1]August through December 1980

Claims

One of the problems anticipated in the design of the demonstration was ensuring a smooth transition of Medicare beneficiaries from the fee-for-service Medicare system into the KPMCP. One significant aspect of this transition relates to the "lock-in" provision of prospective payment; that is, the requirement that all beneficiaries must receive all nonemergency care in the KPMCP. During the start-up phase, the number of outside claims posed a significant problem. In order to ensure an orderly transition, the Health Plan agreed to pay most claims for out-of-plan use, even though it had a legal responsibility to pay claims only for in- or out-of-area emergencies or for serious illness out-of-area. All first and second Part A claims for covered services received from Medicare Plus members before June 1, 1981 were paid. Most Part B claims during the same period were also paid.

A total of 1,572 claims were paid for all outside services used in 1980. These claims totaled $685,000, of which 74 percent of the dollars and 65 percent of the claims were for nonreferred services. Most of these claims would have been rejected for other Health Plan members but were paid for Medicare Plus members during the first 10 months of the experiment. While 85 percent of the 1980 nonreferred claims were Part B claims, 87 percent of the dollars spent were for Part A.

Almost 90 percent of the outside claims were incurred within the first two months of membership. A higher proportion of older members submitted claims than younger members (Table 11). The 789 members (for whom 1,572 claims were paid) represent almost 12 percent of the total membership. (This table includes members who were referred for outside services, as well as those who submitted claims for nonreferred services.) Twenty percent of members for whom outside claims were paid for service in 1980 had terminated by June 1981.

TABLE 11

Medicare Plus
Age Distribution of Members
and Members Who Submitted Claims, Year End 1980

Age Groups	Total Membership	Members with Claims	% of Total
Less than 65	233	38	16.3
65-69	2,130	202	9.5
70-74	1,884	204	10.8
75-79	1,305	169	12.9
80-84	705	103	14.6
85 and over	399	73	18.3
Total	6,656	789	11.9

Several strategies were developed to bring this problem under control. The most important was the implementation in the region of a new position, the Patient Care Coordinator, who was charged with contacting the hospitals of the community and facilitating the transfer of members to KPMCP hospitals.

Claims decreased markedly after 1980. The cost per member, per month for the first six months of 1981 was $10, less than half the amount of the preceding period. As a result of the policy change in June 1981, costs dropped further to $3.22 per member, per month, excluding referred services.

Summary

The Medicare Plus project demonstrated that it is possible to design a workable prospective payment system and that Medicare beneficiaries can be motivated to join an HMO by offering them a premium saving or more benefits than they usually have available. Although outpatient utilization was somewhat higher than predicted, inpatient utilization was near predictions for this population. Initially high claims experience was probably prolonged by a deliberately lenient claims policy, but the problem was controlled by the end of the first 12 months. An annual cancellation rate of approximately 5 percent indicates a high level of member acceptance.

The enrollment of 5,500 new Medicare members into the KPMCP raised the percentage of over age 65 members from 6.8 percent in 1979 to 9.4 percent in 1981. As a result the KPMCP now serves 17 percent of all Medicare beneficiaries in the Portland SMSA. The Health Plan's overall market penetration for 1981 was 19 percent.

These findings indicate the feasibility of public policy encouraging enrollment in HMO's by increasing their participation in the Medicare program. They also demonstrate that increasing Medicare enrollment in HMO's has a potential to help contain Medicare costs and decrease hospital utilization for an increasingly aged population in the United States. The provisions necessary for encouraging more HMOs to compete for Medicare business are now enacted into law in the Tax Equity and Fiscal Responsibility Act of 1982. By year end 1983, the final regulations should be in place to allow all qualified HMO's to enter into prospective payment contracts with HCFA. This first report on the payment, marketing, and enrollment aspects of the KPMCP Medicare Plus demonstration will be followed by a series of research reports of other findings related to utilization, member satisfaction, and provision of new services.

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Survey Finds Elderly "Highly Satisfied" With Kaiser Portland's Medicare Plus Program

A membership satisfaction survey of the three and a-half year old Medicare Plus demonstration program at the Kaiser Permanente Medical Care Program in Portland, Oreg. indicates a "highly satisfied" Medicare Plus membership.

Data from the survey reveals that 92 percent of the respondents were satisfied and only 2 percent dissatisfied with the KPMCP in general. This satisfaction increased to 95 percent, with 1 percent dissatisfied, when those with visits during the past four weeks gave an overall rating to their most recent visit.

The findings further show that some dissatisfaction was expressed with the appointment process and telephone systems, and with the lag time between calling for a routine appointment and the date of the appointment. And, some problems were encountered with using the KPMCP. However, less problems and less dissatisfaction were expressed by these new, aged members than is expressed by the general population in the routine KPMCP satisfaction survey.

A total of 1,348 Medicare Plus enrollees responded to the survey. This represents an 82 percent response rate which is considered "very high," but not unexpected, says the survey. Medicare members of KPMCP generally respond "very well" to the ongoing membership surveys, it points out.

Two noteworthy characteristics were mentioned regarding these respondents. The first is that 90 percent of them have lived in the Portland metropolitan area for more than 10 years. The second is that 55 percent of the newly enrolled members said their health was better than others around their own age. Thirty-eight percent said their health was the same as others. And 7 percent said their health was worse. These data are similar to what conversion members reported except that 9 percent reported their health as worse than others. The survey points out that "more" research is needed to determine if the elderly who leave their current forms of medical care and join HMOs differ in health status from those who remain in the fee-for-service Medicare program.

The survey's findings further reveal that new services and informational sources which were provided to assist the Medicare Plus members in understanding their benefits and in using KPMCP services are popular and useful.

Furthermore, low cost (of premiums and out-of-pocket costs) was the most important reason for enrolling in this program, but the security of knowing that high-quality medical care is available when needed (without creating a financial burden) was also very important, the survey says.

The data also show that most respondents—80 percent—have a regular doctor at KPMCP and 84 percent believe KPMCP doctors are as good or better than other doctors. Less than 5 percent rated the overall access to care at KPMCP as dissatisfactory.

The survey was mailed in December 1981 to a 25 percent sample of Medicare Plus units. The study population was selected by subscriber units rather than individual health plan members, although the survey was sent to all eligible Medicare Plus members in the randomly selected units.

The survey's data is categorized into type of member and medical coverage. In the first group, members are either newly enrolled in the Kaiser-Permanente program or those who converted to Medicare Plus from their existing KPMCP Medicare supplemental coverage.

(See Survey of Kaiser's Medicare Plus Program, p. 12)

Over 75 Percent of Elderly Satisfied With Kaiser Portland's Physicians, Survey Finds

(Continued from p. 11)

In the second, coverage is either regular (base coverage only) or special benefits pertaining to members with base coverage who also purchased additional benefits, for instance drugs, eyeglasses or contact lenses, hearing aids or dental care.

More detailed findings from the membership satisfaction survey reveal:

- Over 75 percent of the 1,247 Medicare Plus respondents who evaluated the Kaiser Permanente Program said they were either satisfied or very satisfied with the technical knowledge, ability and competence of KPMCP physicians. Less than 2 percent indicated dissatisfaction, with the remaining 22 percent having no opinion;
- Conversion members—those who were enrolled in KPMCP under an existing Medicare supplement prior to converting to the Medicare Plus capitation program—were more satisfied, 86 percent, with the overall capabilities of KPMCP physicians than newly enrolled members, 72 percent;
- More visits were reported for the time period after becoming Medicare Plus members (an average of 4.9 visits) than before joining Medicare Plus (3.1 average visits per member). After enrolling in Medicare Plus, new members had more visits than conversions. And, those with special benefits had one more visit per member than those with regular coverage (5.4 and 4.4 average visits respectively).
- Of those who contacted the Medicare Plus office, 71 percent reported being very satisfied with the information or assistance they received, and 21 percent were satisfied. Only 8 percent were dissatisfied. Of the newly enrolled members, 22 percent said they have had trouble reaching the Medicare Plus office by phone.
- With regard to the Medicare Plus Member Handbook, 77 percent of the newly enrolled members referred to their handbook to help them make an appointment; 36 percent used it to help them select their doctor; and 45 percent used it to find out how to get in touch with their doctor.

The Medicare Plus project of the Oregon Region Kaiser-Permanente Medical Care Program, which began in August 1980, was designed as a model for prospective payment to increase HMO participation in the Medicare program. The project demonstrated that it is possible to design a prospective payment system that costs the Medicare program less than services purchased in the community from fee-for-service providers. The project would provide appropriate payment to the HMO. And, it could create some financial "savings" that would be returned to beneficiaries in the form of comprehensive benefits to motivate them to enroll in the HMO.

Medicare Plus recruited 5,500 new and 1,800 conversion members into the demonstration, through use of a media campaign, a recruitment brochure, and a telephone information center, according to the Summer 1983 *Health Care Financing Review* journal in which an article appeared entitled "Kaiser-Permanente's Medicare Plus Project: A Successful Medicare Prospective Payment Demonstration." Members recruited were a representative age and geographic cross section of the senior citizen population in the Portland, Oreg. metropolitan area.

ITEM 4

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Fallon's Senior Plan: A Summary of the Three Year Marketing Experience

Daniel B. Wolfson
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INTRODUCTION

Historical Context of Fallon's Demonstration Project

In the summer of 1978 Fallon Community Health Plan responded to a Health Care Financing Administration (HCFA) request for a proposal entitled "Alternative Models for Prepaid Capitation : Financing of Health Care Services for Medicare/ Medicaid Recipients" (No. 50-78-0082). The Plan was one of five demonstration sites that went operational. The other contractors were Kaiser-Portland, Greater Marshfield Community Health Plan in Wisconsin, Health Central in East Lansing, Michigan, and a consortium of HMOs in the Minneapolis area. Reimbursement under demonstration projects was on a prospective risk basis, similar to that subsequently enacted in the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982.

On April 1, 1980, the Plan became the first demonstration project to enroll Medicare beneficiaries and to receive reimbursement by the government on a per capita, prospectively determined basis. Fallon's adjusted community rate (ACR) reimbursement methodology includes calculation of 95 percent of adjusted average per capita costs (AAPCC), which is central to the TEFRA reimbursement formula. The project originally was intended to terminate in 1982, but was extended for three years.

Description of the Project

The Fallon Community Health Plan is a single group, group model health maintenance organization located in the Worcester, Massachusetts area. It provides services to its members through the facilities of the Fallon Clinic, a large, well-respected, multi-specialty group practice. The Plan was sponsored jointly by the Fallon Clinic, Inc. and Blue Cross of Massachusetts. It became operational in February, 1977 and was federally qualified on November 21, 1978.

Until June, 1979, members were from employer groups or converted from employer groups. At that time, approximately 200 Medicaid beneficiaries from the Aid to Families with Dependent Children category were enrolled. Prior to the Senior Plan, members turning 65 and becoming eligible for Medicare were terminated from the Plan and converted, primarily, to Blue Cross and Blue Shield coverage.

The Worcester area has one of the highest percentages of Medicare-eligible persons in the country—16 percent. Worcester, also, has one of the highest hospital-bed-to-population ratios in the country—over eight hospital beds per 1,000 persons. The area experiences extremely high hospital utilization for persons "over 65" with approximately 4,700 hospital days per 1,000 persons. Worcester area elderly face the same problems experienced throughout the elderly population, namely, uncertainty about the cost of health care and inability to cope with increased medical bills while on fixed incomes. Supplemental insurance premiums are increasingly prohibitive. Blue Cross supplemental coverage in 1983 was over $34.00 per month.

The plan developed enrollment projections so that the percentage of Medicare beneficiaries in its HMO population would be equal to the 16 percent of Medicare beneficiaries in the general population of the service area. The Plan made the program attractive to Medicare-eligible persons by providing additional benefits not covered by Medicare or Blue Cross/ Blue Shield of Massachusetts supplemental Medicare coverage, "Medex". These included full coverage of all outpatient clinic services, preventive services, refractions and eyeglasses, as well as prescription drugs with a small copayment. In addition, these benefits were to be offered at a rate well below "Medex".

The Plan was paid a prospectively-determined rate from HCFA, based on an adjusted community rate (ACR). That rate would not exceed 95 percent of the adjusted average per capita cost (AAPCC). The results of this reimbursement model over four years have been:

	HCFA CONTRIBUTION	MEMBER DUES	PERCENTAGE OF AAPCC
1980	$119.12	$ 7.50	91.4
1981	$120.19	$ 7.50	95
1982	$144.87	$15.00	95
1983	$177.02	$15.00	95
1984	$194.67	$15.00	95

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Denyse A. Newbery is the director of Marketing and Community Relations at Fallon Community Health Plan. With her extensive HMO marketing background and Senior Plan experience, she has become a recognized expert in the field.

This project was performed under Contract No. HCFA 500-78-0082

In entering this program, the Plan attempted to accomplish the following objectives:

1. Demonstrate that the Plan could market to this population and attract a significant number of enrollees;
2. Demonstrate that the Plan could operate a prepaid Medicare program in a cost-effective manner and achieve savings for HCFA and members;
3. Demonstrate that a program such as the "Senior Plan" would increase the receptiveness of health maintenance organizations to Medicare risk programs; and
4. Demonstrate how a prepaid Medicare program could be developed successfully in a health maintenance organization of moderate size.

We believe that the three year enrollment of 7,200 members warrants the assertion that, among other factors, the marketing formulations and techniques used were effective. In fact, the enrollment projections were reached and exceeded each year. Low disenrollment is similarly consistent with our belief that there was a high level of member satisfaction.

The following sections deal with the benefit content, marketing concepts and member management.

BENEFIT PACKAGE

The Senior Plan benefit package is a comprehensive set of benefits made available to Medicare beneficiaries in lieu of traditional Medicare coverage. Only one high option is offered to aged and disabled Medicare beneficiaries. It is not configured on a basic supplemental format.

Benefits are offered during an annual, time-limited, open enrollment period without medical review, on a first come, first served basis, without waiting periods or pre-existing condition exclusions. Only residents of Worcester County who have Medicare Parts A and B are eligible for enrollment.

The Senior Plan provides benefits beyond Medicare and "Medex". These benefits include preventive services, such as physical examinations, nutrition services, social services, refractions, eyeglasses, and prescription drugs subject to a copayment. Such additional benefits are tremendously important to a population with limited financial resources.

Savings derived from the HMO's efficiency in delivery of Medicare Parts A and B services are used to finance these additional benefits and maintain affordable membership dues. The present Senior Plan dues of $15.00 per month is far below the high option "Medex" premium of over $34.00 per month. The only out-of-pocket payment from the member is a copayment for prescription drugs. At the beginning of this year (1984) that copayment was eliminated.

MARKETING AND ENROLLMENT

Marketing Techniques

Appropriate marketing techniques were applied to each defined population subset. These segments included non-group "Medex" subscribers, "Medex" retiree/employer groups, and Medicare beneficiaries with other carriers, or no supplemental coverage at all. The Senior Plan was offered on a "dual choice" basis to as many Medicare beneficiaries as possible. Four open enrollment periods were conducted from 1980 through 1983. All open seasons were conducted from September 15 to November 15 for effective dates in January, February and March, except for the initial open season, which was conducted from February to April.

The marketing strategy was multifaceted. The first technique used was a public relations campaign aimed at all segments of the population. It included open houses, newspaper advertisements, radio spots, and a speaking program. The general purpose of the campaign was to reach Medicare eligibles without a "Medex" supplement and to reinforce other marketing efforts.

During each open enrollment period, five to six open houses were conducted on Sunday afternoons at the Fallon Clinic facilities. These meetings attracted from 200 to as many as 700 people. Presentations to the elderly were done in an effort to provide clear understanding. Emphasis was placed on use of emergency services, the lock-in provision, benefits, rates, and the HMO system.

Newspaper advertisements were placed in the two city newspapers and in several town newspapers. It requested interested people to send in a coupon asking for additional information. Each year the ads netted approximately 500 to 1,500 coupons, of which one-half actually resulted in enrollment in the program.

Prior to the initial enrollment and on a continuing basis, marketing representatives approached several Senior Citizen groups, including apartment, retirement and church groups. These presentations were, in large part, to audiences of under 50 people but they provided a sound forum to explain Senior Plan. Prior to the first open enrollment, a Senior Plan Health Fair was conducted. Over 4,000 Worcester residents attended the fair which provided information on blood pressure, diabetes, glaucoma, and the Senior Plan. It was an excellent method of introducing a new product to the community in a pre-marketing stage.

Non-group "Medex" subscribers were contacted through the mail during the start of the open enrollment periods. Each mailing contained a Senior Plan brochure, an application and an invitation to attend one of the open houses. There are approximately 27,000 non-group "Medex" subscribers, representing 50 percent of the entire Medicare population. The mailing allowed the Plan to approach the maximum number of Medicare eligibles in the service area. Forty-nine percent of the total Senior Plan enrollment were former non-group "Medex" subscribers. However, applications via mail increase the danger of misunderstanding of the program content by the members. Mailing of applications caused some unauthorized out-of-Plan use because of a lack of understanding of the emergency procedures and the lock-in provision of the program. For the 1983 and 1984 open enrollment periods, all interested persons came to an open house, or came to the Plan administrative offices to fill out an application, or were contacted by phone.

The employer group "Medex" subscriber enrollment was conducted in much the same way the Plan enrolls "under 65" employer groups. Senior Plan materials most often were sent directly to the home of retirees by the employer. A cover letter on Fallon Community Health Plan letterhead accompanied the literature package which included the Senior Plan brochure and a cover letter from the employer inviting them to a meeting on the company site. Marketing representatives usually spent an hour and a half giving the formal presentation and answering questions. All retirees also were invited to several special open houses conducted at the Fallon Clinic.

The GroupHealthJournal Spring 1984

Results of Marketing Strategy

Our most optimistic enrollment projections were exceeded. Our projection was that the percentage of Medicare beneficiaries in the Plan's covered population would be equal to the percentage in the service area, 16 percent. The Senior Plan membership represents only 15 percent of the total enrollment because of the rapid growth of the "under 65" population. Even though the percentage is 15 percent of the total enrollment, it is the rapid growth of the "under 65" program and Fallon Clinic capacity limitations that belies the real growth and attractiveness of the Senior Plan.

END OF YEAR	PLAN SENIOR	"UNDER 65"	SENIOR PLAN PERCENTAGE
1980	3,600	25,962	12
1981	5,200	29,671	15
1982	6,300	35,550	15
1983	7,200	41,709	15

A tracking system was established in 1981 to indicate the marketing method used. The results are as follows:

METHOD	METHOD %
Open Houses	29
Walk-ins	35
"Medex" Mailings	23
"Medex" Group Subscribers	13
	100

"Medex" mailings increased the numbers of persons submitting applications at open houses and at the Plan's administrative offices. The percentage reflect the Plan's attempts to strongly encourage persons to attend an open house and some of the restrictions placed on releasing applications.

The estimated percentage of the Senior Plan enrollees according to their prior health coverage is as follows:

	PERCENT OF ENROLLED POPULATION	PERCENT OF GENERAL POPULATION
Group Medex	13	13
Non-Group Medex	49	41
Non-Medex	38	46

The Senior Plan was offered on a dual choice basis by 60 local Worcester employers to Medicare eligible retirees. The employers offering the program thus far, have offered it as an alternative to high option "Medex". From 1980 to 1983, 925 Medicare retirees opted for the Senior Plan. This represents a penetration rate of 16 percent. This rate matches the experience for the employers offering the Plan to their "under 65" population.

The Senior Plan penetration rates for groups of over 50 refirees ranged from a low of four percent at New England Telephone to a high of 38 percent at Warner-Swasey, a heavy equipment manufacturing company in Worcester. The largest area group, Norton Company, enrolled 11 percent of its 2,200 eligible retirees. The second largest group, Wyman-Gordon Company, enrolled 26 percent of their 600 retirees.

Most companies contributed 100 percent of the premium cost for the competing "Medex" certificate. The remaining companies had equal dollar contribution. The Plan was able to offer most local companies the Senior Plan at substantial savings. There seems to be no significant difference in penetration rates between companies contributing fully and companies requiring a retiree contribution. Disenrollment from groups was minimal.

The marketing department not only emphasized the cost and benefits of the Senior Plan but also the qualifications and commitment of the physicians, the convenience of services and the absence of claim forms. During August of 1982, the Plan surveyed a random sampling of Senior Plan members. When asked what were important reasons for joining the Senior Plan, members responded as follows:

Cost	97%
Quality	96%
Additional Benefits	94%
Desire Preventive Medicine	92%
Location	89%

Characteristics of the Population

As compared to the Worcester area population, the Senior Plan members can be characterized as younger, disproportionately male, from towns close to Fallon facilities, less "institutionalized", and better insured. The AAPCC includes adjustments for these characteristics.

The average age of the enrolled population "over 65" is somewhat younger than the non-HMO "over 65" population. The average age of the non-HMO Worcester County population is 75.27 years as compared to over 71 years for Senior Plan population. However, the aging of the enrolled population reduces this difference as evidenced by these figures.

	AVERAGE AGE OF SENIOR PLAN	PERCENTAGE OF 65–89	85+
1980	71.21	42.7	3.62
1981	71.32	40.6	4.01
1982	71.79	39.9	4.26

There is an unfavorable proportion of males enroiled; approximately 48 percent of the enrolled population as compared to 38 percent of the non-HMO aged population. Males past the age of 55 tend to be higher utilizers of health care. It appears, however, that the percentage of males has decreased over time from 49.7 percent of the members to 47.9 percent of the members.

The urban-rural mix of the enrolled population closely approximates the county's distribution. Over 40 percent of the Senior Plan enrollees reside in the city of Worcester. The penetration rates are higher in towns within close proximity to the Fallon Clinic facilities and in towns in the southern portion of the county, partially caused by a low physician supply.

The enrolled population also tended to be better insured than the general population. Approximately 38 percent of the enrolled population did not have prior "Medex" coverage. The Senior Plan has a lower portion of institutionalized patients than the general population. Some Medicare beneficiaries transfer to the Senior Plan while hospitalized. Their hospitalization becomes the financial responsibility of the Plan on

the day coverage begins. This situation occurred with 10 Senior Plan members in 1980.

Disenrollment

Disenrollment, obviously a deep concern, has been carefully scrutinized. The marketing department knows that new enrollments are clearly tied to disenrollments and that this may be the best barometer of member-satisfaction in this new venture. The disenrollment rates, including deaths, were three percent in 1980, eight percent in 1981, and five percent in 1982. In May of 1981, the Plan began surveying members terminating from the Senior Plan. The questionnaire is self-administered by mail as part of a termination notice system. Once a request for termination is made, the member is sent a verification notice requiring the member's signature and a questionnaire. The results are summarized below for 1981 and 1982.

REASON	1981	1982
Lock-in provision	24%	19%
Dissatisfaction with delivery system	22%	19%
Transportation	14%	12%
Relocation	19%	18%
Expense	3%	4%
Other	18%	28%

The lock-in provision, although not a major deterrent to enrollment, is an important factor in member retention. Potential members require a full explanation of the lock-in provision at all marketing presentations and in all promotional literature. Part of the lock-in provision phenomenon is the desire of members to return to their previous physicians. It was originally suspected that long standing physician-patient relationships would inhibit HMO membership growth. The advantages of the savings to the member seem to have outweighed the disadvantages of changing physicians. However, once enrolled, a small minority do feel uncomfortable and do return to their physicians.

ENROLLMENT MANAGEMENT

One of the lessons learned from the Senior Plan is the importance of repeated instruction to members in HMO procedures. Although the number of unauthorized provided services is relatively low, the cost of such services is disproportionally high. By the spring of 1981, the marketing staff had gathered sufficient information to evaluate the strengths and weaknesses of the Senior Plan membership. It was felt a small percentage of the population were uninformed as to proper Senior Plan procedures. The marketing staff alone with its Senior Plan Advisory Committee developed educational tools and literature which improved awareness of Senior Plan procedures.

Since Spring 1981, all existing members receive the following:

1. "Just a Friendly Reminder" an outline of Plan procedures and key phone members that Senior Plan members should have;
2. Telephone stickers (for the cradle of the telephone) listing the different Fallon Clinic emergency phone numbers;
3. A single identification cardholder that contains the Senior Plan and Medicare cards. It clearly identifies members of the Senior Plan to non-Fallon physicians and hospitals. The cardholder also informs providers that services must be pre-authorized except for severe emergencies; and
4. A special Senior Plan newsletter sent to all members, which includes articles on Plan procedures.

Since these steps were taken, claims for unauthorized services have been drastically reduced. All new members are now given the cardholder and telephone sticker upon enrollment. Further procedure reinforcement designs are being planned.

The marketing department pays special attention to the Senior population. It employs a Senior Plan marketing specialist. It has a special membership service section. A Senior Plan Advisory Committee, selected from the membership itself, contributes greatly to our insight into member needs and Plan deficiencies. One Senior Plan specialist deals with marketing and enrollment activities constantly. Inquiries are thus addressed throughout the year and arrangements made for timely entry.

The Plan's membership service department takes members' complaints, attempts to resolve members' problems and educates members on the benefit content. This department presently is staffed by three full-time service representatives. The incidence of complaints is relatively low among Senior Plan members. Many of the complaints deal with the accessibility of physicians, that is, the length of time it takes to schedule an appointment to receive medical care services.

The Senior Plan Advisory Committee is comprised of seven members of the Senior Plan who are engaged in community activities involving the elderly. Its purpose is to provide feedback on the provision of medical care and to provide advice on the Plan's marketing literature and promotional activities. The committee helped develop the educational tools which would be most effective in heightening members' awareness of Senior Plan procedures.

SUMMARY

Fallon demonstrated that through a well-orchestrated marketing campaign and well-designed benefit package a substantial number of Medicare enrollees would join an HMO. Existing physician-patient relationships and the lock-in provisions are not insurmountable obstacles in enrolling the "over 65" population. A competitively priced, generous benefit package, marketed in a clear and understandable manner to a large audience of Medicare beneficiaries are the key elements to successfully market a Senior Plan type program. Enrolled members need to be educated and re-educated in HMO emergency procedures and in the lock-in requirements. An important resource for an "over 65" program is a membership service department designed to assist members with their problems.

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Field testing nationwide is now under way to test the feasibility of delivering combined health and social services to an elderly population. The social/health maintenance organization (S/HMO), incorporating features of health maintenance organizations with the home care approach of community social services, will be financed on a prepaid, capitated basis through premium contributions from Medicare, Medicaid, and enrollees. It will test whether social services can reduce medical costs and whether institutional days can be reduced, family care maintained, and health and quality of life enhanced.

Elder Care for the 1980s: Health and Social Service in One Prepaid Health Maintenance System

Larry M. Diamond, PhD,[1] Leonard Gruenberg, PhD,[2] and Robert L. Morris, DSW[3]

The policy thrust of the "new federalism" proposals in the health care sector is to reduce the level of government expenditure, limit demand for services, and decentralize, if not altogether abolish, current regulatory controls in favor of competitive market mechanisms. This paper considers the feasibility of a health system reform (the social and health maintenance organization — S/HMO) that addresses each of these goals — a system of health and social services for an elderly population, including individuals in need of long-term care, financed on a fixed budget basis. It builds upon the widely held belief that more comprehensive, integrated, and managed systems of health care can result in significant cost savings in contrast to the current separation of acute and chronic care fee-for-service programs which discourage the efficient use of alternatives. Preliminary evidence of the efficacy of comprehensive medical care services is seen in the recent HMO Medicare demonstration project (Greenlick & Lamb, 1981; Wolfson & O'Connell, 1981). The S/HMO combines selected features of the Personal Care Organization (PCO) with those of the medical model Health Maintenance Organization (HMO), specifically, locally centralized case management capacities coupled with locally centralized control of essential care and long-term care services.

The social/health maintenance organization (S/HMO) is a managed system of health and long-term care services. Under this model, a single provider entity assumes responsibility for a full range of acute inpatient, ambulatory, rehabilitative, extended care, home health, and personal care services under a fixed budget which is prospectively determined (see Appendix). Elderly persons who reside in the target service area are voluntarily enrolled through the marketing efforts of the S/HMO provider entity. Once enrolled, they are obligated to receive all S/HMO covered services through S/HMO providers, similar to operations in a medical model health maintenance organization. The S/HMO will thus test, for the first time, the degree to which preventive health care can delay the dependencies (if not the infirmities) associated with aging and prevent or delay institutionalization. Enrollment is voluntary but with limits on "openness" to preclude overenrollment of either high- or low-risk subscribers. Although capitation levels could be adjusted when an area has a higher than average proportion of high-cost enrollees, a controlled enrollment procedure will be necessary to produce a reasonable average cost.

Financing would be arranged by pooling individual premiums, Medicare, Medicaid, and possibly block grant or Title IIIb funds under the Older Americans Act. The S/HMO provider would share financial risk with public third-party payers for costs above the negotiated capitation budget. The provider would either staff and deliver all of the required services or, more likely, contract in advance with other providers for some of them. Capitation financing promises the most efficient combination of services with the least delay in delivery and with no more risk to quality of care than now prevails among conventional HMOs or elsewhere in the health care delivery system.

The S/HMO model is in the initial stages of field testing at four sites as part of a national demonstra-

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tion project funded by the Health Care Financing Administration (HCFA) at the Florence Heller Graduate School at Brandeis University, where the model was originally conceived (Diamond & Berman, 1981; McCaffrey & Winn, 1978; Morris, 1971). The sites selected are a large, mature HMO with a sizeable elderly population; a nursing home/community services complex; a case management entity; and an HMO/community long-term care partnership. After the sites have begun enrollment in early 1983, an external evaluator will assess enrollees in terms of their demographic characteristics, health status on entering, and health outcomes — including the ability of the S/HMO to prevent, delay, and/or reduce institutionalization. Other factors will include the kinds of services most used, the effect of the S/HMO on patterns of informal care, comparative consumer costs, and costs to each third payer.

Specifically, the S/HMO demonstration project will test such questions as the following: Does the S/HMO reduce institutional services for the severely impaired (i.e., prevent or delay admissions, reduce lengths of stay, enable discharge from the hospital to the community rather than nursing home, etc.)? Does the S/HMO alter cost patterns? Individual per capita? The amount individuals pay out of pocket? The amount Medicare pays for the frail end of the spectrum? The amount Medicaid pays per capita?

The arguments for and against such comprehensive, integrated care systems are not new. We present here only the empirical basis for belief that such a localized system can succeed within the context of the current debate over the "new federalism."

The Legal Precedent

Statutory authority to negotiate prepaid contracts with a variety of providers for both social and medical services already exists in the Medicaid and Medicare programs administered by the Health Care Finance Administration and under the new Social Services Block Grant. Section 222 or 1115 waivers under the Social Security Act now allow for alternative modes of payment, services mix and reimbursement, client eligibility criteria, and rate-setting methodologies and mechanisms for experimental medical programs. HMOs may contract with either Medicare or Medicaid on a prepaid basis while offering a benefits package that varies considerably from the services ordinarily covered by either funding source. Seven experimental HMOs operate prepaid risk-sharing contracts.

Recently, Section 2176 of the Omnibus Medicare/Medicaid Reconciliation Bill of 1981 provided incentives under Medicaid to add community-based long-term care services to state programs and to simplify the waiver process. Previously, six Medicaid waiver demonstration projects incorporated homemaker and chore services, nonmedical transportation, meals, escort/companions, and respite care while five offered housing assistance or modification. Additionally, Older Americans Act and Social Services Block Grant funds can be used to supplement capitated Medicare and Medicaid funding. For example, state units on aging can contract with S/HMO providers to offer additional in-home services or S/HMO enrollees who are recipients of Title IIIb or Title XX services may continue to receive those services as supplements to the S/HMO package through informal arrangements with local vendors.

In short, the legal mechanisms for pooled, prepaid contracts for the full scope of health and social services to be delivered through a S/HMO are essentially in place. However, no single provider, to our knowledge, has pursued a complete package of waivers under these authorities to manage an integrated service system for the elderly.

Single-Stream Funding

Providers of long-term care face an almost impossible task of securing third-party reimbursements for appropriate services from disjointed funding streams. Nor can they implement creative, unstandardized service plans linking outside supports with informal, in-home helpers. Single-stream financing with broad latitude in service design makes the S/HMO project distinctly attractive to providers, a gain coupled with a likely reduction in the overwhelming paperwork and related cash flow problems imposed by a maze of third-party reimbursements. In addition, there is some evidence that rates could be set at a level close to the prevailing fee-for-service rate and yet offer good net savings under a managed care system (Trieger, et al., 1981). These savings could be used for improvements and expansion or to provide additional service benefits to enrollees.

High on the list of incentives for S/HMO enrollees would be the elimination of the maze of confusing, anxiety-provoking bills for services, multiple copayments, and deductibles which accompany the Medicare program. Under the S/HMO only a monthly premium would be charged, a fee probably comparable to current out-of-pocket outlays. Moreover, a wide range of services, both medical and social, would for the first time be centrally accessible to individuals having serious functional impairments. Thus, for a modest premium, the elderly could secure help for the conditions that they most worry about. This is particularly true for the chronically impaired, whose Medicare coverage is, at best, minimally supplemented by privately arranged "medigap" insurance policies.

Cost-Saving Potential

Previous long-term care demonstrations (Applebaum et al., 1980; Bernier & Quinn, 1980; Eggert et al., 1977; Hodgson & Quinn, 1980) have shown that substituting in-home for institutional services has resulted in an improved quality of life and reduced costs for individual clients. These studies, however, do not clearly indicate a resultant reduction of costs to the system, nor do they cost out the effect of expanding benefits to many new beneficiaries (Weissert et al., 1979). It is anticipated that the capping of

the budget at the provider level will motivate the S/HMO to develop procedures for rationing the expanding benefits in a way that will achieve cost-effective tradeoffs. Whether these substitutions will benefit clients must be addressed in the evalution of the model.

Establishing Financial Feasibility

The following macro-level analysis of health care expenditure data obtained from HCFA indicates that it may be possible to finance likely increases in ambulatory care and in community support services through savings in the acute hospital and long-term nursing home care sectors. Table 1 displays estimates (Fisher, 1980; Leutz, 1981) of the national per capita expenditures for health and social services for elderly in 1978. Of a total annual per capita expenditure of $2,065, more than two-thirds was spent on acute and long-term *inpatient* care. In contrast, home health and nonmedical home care services accounted for only a little more than one-twentieth of total expenditures.

In the S/HMO, it is anticipated that an increased emphasis will be placed on ambulatory medical care and home care services. Experience from HMOs (Corbin & Krute, 1975; Lennox, 1978; Luft, 1981; Weil, 1976) suggests that an expected reduction of 25% in hospital expenditures is not unreasonable while ambulatory care costs may be expected to be 10% higher than current costs. Estimates for home care costs are more difficult to obtain because the range of services offered by home care programs is unique to a specific population. Since the S/HMO would enroll a broad cross-section of elderly, it is likely that only a small proportion of enrollees (5 to 10%) would use long-term care services in a given year because the group will represent a normal profile of aged. Future utilization will depend on the capacity of a S/HMO to maintain the same profile by new enrollment, or its capacity to adjust capitation rates as the enrolled population matures. To estimate long-term care costs for the S/HMO, it is thus necessary to extrapolate from program-specific user data.

We made these estimates by starting with data obtained from the Triage long-term care demonstration program which has been in operation in Connecticut since 1976. Unique among such programs, Triage opened its doors to all persons aged 65 and over while targeting its long-term care services through a case-management approach. Although the open enrollment feature of Triage would suggest a clientele similar to that anticipated for the S/HMO, the reported data (National Center for Health Services Research, 1979) show considerable bias towards the disabled. Thus, it was necessary to analyze Triage costs and utilization rates for individuals of differing levels of disability, standardizing them to obtain a national cross-section of elderly (Gruenberg, 1981). The results are uncertain, in part because of the difficulty of comparing local and national data that use different measures of disability and in part due to different assumptions as to the generosity

Table 1. 1978 Elderly Per Capita Costs for Health and Social Services

Type of service	Cost	Percent
Hospital	$869	42
Nursing home	518	25
Physician service	366	18
Home health service	65	3
Nonmedical home care service	55	3
Drug and sundries	133	7
Eyeglasses, appliances, other	59	2
Total	$2065	100

with which a given S/HMO will dispense long-term care services. In the following discussion, we will assume that S/HMO home care costs, when spread over the entire enrollee population, will be halfway between our low and high estimates, or, in 1978 dollars, $30 per month.

A comparison between expected S/HMO expenditures and expenditures in the current system presented in Table 2 shows that, despite a 200% increase in expenditure for home health and nonmedical home care, a reduction of 11% in nursing home expenditures and 25% in hospitalization expenditures would ensure that per capita expenditures in the S/HMO, with its expanded home care and ambulatory care, will be no greater than in the present system. These cost reductions appear to be reasonable objectives for a managed system of services after sufficient time is allowed for such a program to reach maturity.

As shown in a recent study (Keeler et al., 1981), the nursing home population includes two subgroups, one with an average length of stay of 45 days and another with an average stay of 30 months. The short-stayers account for nearly three-fifths of all admissions to nursing homes, but the long-stayers account for more than 90% of all patient days. Thus, the bulk of nursing home costs are associated with the long-stay or permanent residents.

In the S/HMO the aggregate utilization of the short-stay group may increase since nursing homes may be used for some patients as a substitute for hospitals in the final days of an acute care episode. This increase, however, will not have a major impact on total nursing home expenditures because these expenditures are already weighted so heavily toward the long-stayers. On the other hand, even a modest reduction in utilization by the long-stayers would result in savings, as shown in Table 2 For example, if one out of every 20 admissions were prevented and the mean length of stay of those admitted was reduced from 30 to 28 months, the required reduction in nursing home utilization would be accomplished. These goals appear reasonable for an S/HMO.

An examination of hospitalization data from the Health Interview Survey, as shown in Table 3, provides strong evidence that the high costs of hospital care for the elderly are concentrated, to a large extent, in the relatively few whose conditions have resulted in severe disability; these data show that more

than 50% of total patient days are accounted for by 17% of the elderly, who are unable to carry out their major activity. These data suggest that the S/HMO, providing improved primary care, case management, and augmented home care, may have a big pay-off in reducing hospital costs as well as long-term care costs.

It will be necessary to develop estimates for utilization and costs with reference to the characteristics of the enrollees since the S/HMO will be marketed to individuals instead of groups and a wide variation in rates of utilization can be expected. With only a small proportion of enrollees (5 to 10%) likely to require all of the long-term care services and an out-of-proportion part of primary care, it is essential to include health status measures in the projection methods. A review of available data suggests that the degree of functional impairment due to a chronic condition, assessed in conjunction with age and sex, can serve as an adequate basis for projecting utilization and costs. Research is currently being carried out using data from the 1977 Health Interview Survey.

Table 2. Comparison of Projected S/HMO Per Capita Expenditures With Those of Current System

Service	Current system	S/HMO	%Change
Hospital	$869	$652	−25%
Physician services	366	402	+10%
Home health and nonmedical home care	120	360	+200%
Nursing home	518	459	−11%

Table 3. Number of Hospital Days Per Person Per Year by Disability Level, Persons 65 and Over

	Disability Level			
Hospital days	No activity limitation	Limited in some activity	Unable to carry out major activity	Total
Number of days	1.3	1.8	8.4	2.7
% of population	57.0	25.7	17.2	100%
% of total days of subgroup	27.4	17.1	53.5	100%

Source: Unpublished data for the 1977 Health Interview Survey, National Center for Health Statistics, DHHS, Hyattsville, Md.

Pooling of Funds

It is important to examine how public and private sources of financing can be pieced together in a prepaid program and, in particular, whether the premium that would be required from private enrollees is within the range of what an elderly population will be willing to pay for the expanded benefits. In the current system, the financing of long-term care is borne by the relatively small number of individuals (or by public payers in their behalf) who reside in nursing homes or who remain in the community but require household support on an ongoing basis. In the S/HMO, these costs will be spread over a larger population and paid for by a combination of enrollee payments that may include copayments as well as premiums and contributions from public payers.

In order to examine the differences in anticipated utilization and costs in the S/HMO between Medicaid and non-Medicaid elderly, we carried out an analysis of the 1977 Health Interview Survey (HIS). Data obtained from the Health Care Financing Administration regarding the number of elderly receiving Medicaid were used to correct the under-reporting of Medicaid eligibility in HIS. It was assumed that this under-reporting affected the estimated total number who received Medicaid but did not affect the utilization rates. The results are shown in Table 4. Figures

Table 4. Comparison of Medicaid and Non-Medicaid Elderly Population: Prevalence of Disability and Utilization Rates for Hospital, Physician Services, and Nursing Home Care

	(Population in 1000's)		
Disability and utilization rates	Medicaid	Non-Medicaid	Total
Disability[a]			
No activity limitation	805 (27.2%)	11,884 (61.5%)	12,689 (57%)
Limited in some activity	1,111 (37.5%)	4,627 (23.9%)	5,737 (25.7%)
Unable to carry out major activity	1,042 (35.2%)	2,279 (14.6%)	3,840 (17.2%)
Total noninstitutionalized population	2,957	19,309	22,265
Utilization			
Hospital days per person per year	5.1	2.3	2.7
Physician office visits per person per year	9.3	4.7	5.3
Nursing home days per person per year[b]	61.0	9.7	17.7

[a]Disability levels are based on data obtained from the 1977 Health Interview Survey, National Center for Health Statistics, DHHS, Hyattsville, Md.

[b]Data obtained from the 1977 National Nursing Home Survey, National Center for Health Statistics, DHHS, Hyattsville, Md.

for hospital days and physician office visits represent the reported utilization during the previous twelve months for noninstitutionalized elderly, as obtained from the 1977 HIS. It was assumed that the utilization data of those reporting that they received Medicaid was accurate for the Medicaid-eligible group as a whole, and the non-Medicaid group's utilization was recomputed after correcting for the under-reporting of Medicaid eligibility status.

As shown in Table 4, low-income Medicaid elderly are much more likely to experience serious disabilities; more than one out of every three (35.2%) report that they are unable to carry out their major activity as compared with one out of seven (14.6%) among those with above poverty-level income. (In 1978, 15.5% of this group was eligible for Medicaid, according to HCFA.) Not surprisingly, hospital and physician utilization rates are almost twice as high for the elderly poor and nursing home utilization rates are more than six times higher. Table 4 also shows that Medicaid elderly constitute nearly one-third of the severely disabled living in the community, more than one-quarter of hospital and ambulatory services, and more than one-half of nursing home services. In developing a finance plan for the S/HMO, it is thus important to separate out the financing requirements for the Medicaid-eligible.

An examination of reimbursement practices of Medicare and Medicaid suggest how funds from these sources may be pooled for those elderly who are eligible for Medicaid. Medicare currently reimburses HMOs based upon a formula (Gruenberg, 1981) which takes into account the Medicaid non-Medicaid difference in utilization of Part A and B services. According to this formula, in the S/HMO Medicare would contribute a per capita sum, based upon current utilization, nearly two times higher for Medicaid than for non-Medicaid persons. State Medicaid programs, which pay the high costs of long-term care, are likely to benefit from the S/HMO primarily through savings in long-term inpatient care. These savings and the enticement of a fixed budget should offer a sufficient incentive for Medicaid to buy into the expanded home-care benefit that the S/HMO would offer.

For those individuals who are not eligible for Medicaid, financing would rely on Medicare, supplemented by individual premiums. The per capita sum that would be required to pay for a full long-term care benefit (nursing home and home care) would be too high if imposed solely on individual enrollees. (Individuals now pay for these services, but only if and when they need them, often after "spending down" their resources until they become eligible for Medicaid.)

For this reason the S/HMO would need either substantial supplementary funding for services as part of a demonstration program — unlikely in today's political climate — or the long-term care benefits will need to be limited and financed in part by copayments. The S/HMO demonstration will seek a feasible limit on costs during the initial phase, including a limitation in the scope of in-home benefits, careful targeting of services, strategic marketing, and the establishment of copayments for long-term care services beyond a fixed dollar threshold.

Start-Up Costs

It seems evident that in the early stages of operations the S/HMO test sites will face a significant problem in arranging the financing required for the additional home health care benefit proposed. Given the current political climate, it is unlikely that these costs could be met in the traditional manner utilized for new demonstration programs (i.e., through special grant funds). Instead a series of control mechanisms will need to be implemented to insure participating providers against undue levels of risk at the outset of operations. These will probably include some combination of marketing to target groups, liberal risk-sharing arrangements with HCFA and with state Medicaid units, and initial adjustment on the scope of long-term care benefits available contingent on trends in public allocations plus some form of enrollee cost sharing. However, it is projected that, after the initial period of operational experience, the S/HMO benefits package will be enlarged (with provider risk) as the advantages of the managed system are clarified for providers, consumers, and third parties.

Political Climate for Reform

Although logical and empirical evidence argues for the proposed reform, providers are justified in asking why they should assume the risks inherent in adopting a system with several key questions still lacking overwhelming answers. If conventional HMOs and general hospitals have been loath to take responsibility for long-term care in the past, why now?

The answer seems to lie in twin pressures: (1) dissatisfaction in Congress and in the White House with the uncontrolled medical costs fueled in part by a fee-for-service system and (2) the great strain which the elderly or long-term patient places on the acute hospital system. Either the health system will crack, or changes will be forced on it by external political/economic action.

In an era when national regulation and control are relaxing but system pressures are still mounting, the S/HMO offers a health-oriented, voluntary and local road to reform which is based on reasonable empirical evidence and widely accepted health concepts about continua in medical care.

Summary

This article has described a proposed new delivery system, the S/HMO for the elderly, which integrates health and social services into a single model of care. Evidence was provided from several secondary data bases suggesting that the institutional cost savings possible from this managed system would allow for expanded benefits to enrollees at no additional costs to public third-party payers. The aggregate costs to individual enrollees would probably be no greater

than the level of out-of-pocket expenses that they now bear. Providers would gain great flexibility in the services offered, manpower utilized, and settings employed in addition to a buffered initial financial risk and flexible rate schedules. Finally, Medicare and Medicaid can implement the financial and regulatory changes encompassed by the S/HMO without seeking significant legislative changes or new demonstration authority.

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APPENDIX

PROPOSED MINIMUM S/HMO BENEFIT PACKAGE

CORE BENEFITS PACKAGE

Institutional Services:

- *Acute hospital* — Unlimited number of days.
- *Psychiatric hospital* — Current Part "A" benefits (no more than 190 days of care in lifetime).
- *Skilled and intermediate nursing facilities* — 100 days of Medicare SNF care per spell of illness (no prior hospitalization requirement).
  PLUS — 100 lifetime reserve days of regular SNF care or the equivalent value in days of ICF care.*[1]

Medical and Related Services:

- *Physician's services* — Current Part "B" benefits plus preventive health visits.
- *Mental health outpatient visits* — Current Part "B" benefits with annual limit raised to $500.
- *Foot care* — Current Part "B" podiatry benefits plus routine care.*
- *Blood* — Payment for all transfusions.
- *Medical equipment and supplies* — Current Medicare benefits for durable medical equipment, prosthetic devices, and medical supplies.
- *Lab and X-ray*
- *Dentistry* — Current Part "A" and "B" benefits, extraction of erupted teeth, X-rays in conjunction with the above procedures, and emergency care associated with covered problems.

Medical and Related Services (Continued):

- *Outpatient physical therapy and speech pathology services* — Current Medicare Part "B" benefits.
- *Out of area services* — Prior authorization needed, except in emergencies.
- *Pharmacy* — Prescription drugs.*
- *Optometry* — One visit per year for refraction.*
- *Audiometry* — One visit per year.*
- *Eyeglasses* — One pair every two years.*
- *Hearing aids* — One every two years.*
- *Dentures* — One set per demonstration period.*

Home Health and Other Community-Based Services:

- *Medicare home health services* — Unlimited visits per spell of illness for medical conditions that meet Medicare skilled care criteria.
- *Expanded home health and community-based services* — Comprehensive care for chronic or disabling conditions which are not currently covered by Medicare. These conditions require rehabilitation, support, and/or maintenance types

*Copayments, deductibles, or other cost sharing is allowed (at discretion of sites) on these services.

[1]Since nine out of ten SNF days and all ICF care fail to meet the requirements for Medicare SNF care, the coverage of ICF and regular SNF care are significant expansions of benefits over Medicare.

of care. Care will be covered up to a service package value of _____ thousand dollars per month, which is equivalent to one-half the cost of alternative care in the average area SNF.[2] Services available in the expanded package include:

- *Visiting nurse*•
- *Occupational, speech, and physical therapies*•
- *Personal care worker/home health aide*•
- *Homemaker/chore services*•
- *Adult day care/day hospital*•
- *Home-delivered meals*•
- *Medical transportation* — Ambulance and chair car to be included for homebound, disabled.•

• *Case management* — The prescription and provision of services in the home- and community-based services area will be overseen by a case manager or case management team. Case management matches services to needs and also coordinates with provision of S/HMO medical services. Home- and community-based services and case management will be available to both extremely and moderately impaired enrollees.

[2] The actual dollar value of the package will be determined by local nursing home costs. Costs of care may exceed the dollar cap for two months per year if a movement of costs below the cap is expected.

OPTIONAL BENEFITS:

- *Routine and preventive dentistry.*•
- *Additional transportation benefits.*•
- *Respite care.*•
- *Social day care.*•
- *Electronic monitoring.*•
- *Replenishment of lifetime reserve of nursing home days* — Enrollees who use some or all of their 100 lifetime reserve days of regular SNF care (or the equivalent in ICF days) and who subsequently return to the community can rebuild their reserve at the rate of (for example) three days per month of residence in the community.

ITEM 6

THE JOHN TENTEN GROUP

Full-Program Retirement Residences
North 7007 Wiscomb Street, Spokane Washington 99208
(509) 489-7612

GUIDELINES
FOR PERSONS OR GROUPS
INTERESTED IN BUILDING
A "FULL-PROGRAM" RETIREMENT RESIDENCE
IN THEIR COMMUNITY

HOW THE JOHN TENTEN GROUP WORKS

The John Tenten group is a talent pool of specialists representing all aspects of retirement home development: design, financing, construction, marketing, sales, programming and administration.

They have teamed their efforts to offer communities the full range of professional services necessary to build and operate Full-Program retirement residences.

The Group provides a turnkey operation - completely building the residence from concept to completion for the sponsoring organization. The Group is paid normal professional fees for their services (architectural, financial, marketing, sales, and program & administrative setup). Upon completion, the residence is turned over to the sponsoring organization to fully own and operate.

The Group is an independent, professional association, incorporated in the State of Washington, working throughout the Northwest with organizations of all types: church organizations of various faiths, community betterment groups, chambers of commerce, civic and social organizations, health organizations and others.

On the following pages you will find details of how the Group functions:

1. Concepts for providing quality retirement.
2. Financing - how the residences are bought and paid for.
3. Services offered by the Group.
4. Professional makeup of the Group.
5. Building record.
6. Marketing facts.

CONCEPTS

There are a number of inique concepts embodied in the residences built by the Group, which, in total, make the resiednces extremely attractive and marketable.

"Just like home."

Apartments and amenities are built to be home-like, providing the warmth and graciousness that retirees are used to and find comfortable. The apartments are large - generally over 600 to 1000+ square feet. Each contains one or two good-size bedrooms, a large living room / dining room, a full-size, completely equipped kitchen, one or two bathrooms, and ample storage. In the newer developments, each unit has its own sundeck or garden patio.

The Full-Program concept

John Tenten residences go far beyond being just beautiful places to live. The world is full of apartment houses and condominiums that provide four walls, but no support programs whatever. The beauty and power of John Tenten residences is that they provide all the myriad of life-giving, joy generating programs that it takes to make life - not just bearable, but abundant. Here are the four keystones that make up Full-Program retirement:

1. A Meal Program The residents take their main meal each day together in the central dining room. Its a time to dress up and join with friends for a delicious, nutritionally balanced meal served in beautiful surroundings by attractive waiters and waitresses. This one hearty, wholesome meal insures seniors getting the nourishment their bodies need. Breakfast and lunch, they are encouraged to prepare in their own kitchens, or they are offered, optionally, in the dining room.

2. An Exercise Program Regular, planned group and individual exercise programs are offered to help keep minds and bodies young and vigorous. A fully-equipped exercise room is provided, and newer units contain a hot tub/spa, an indoor swimming pool, and a track for year-round walking and jogging fitness.

3. A Prevention & Early Detection Health Program A visiting nurse monitors residents' health watching for early warning signs so illnesses can be caught before they become serious. She works in cooperation with residents' personal physicians, reporting on progress and helping with medication if needed. Frequently a doctor will release an older patient to their own residence rather than remanding them to a nursing home, because they know the nurse is there to watch things and keep the doctor informed - and also because the doctor knows his patient will eat well (see Meal Program, above) and will be surrounded with friends to watch after them.

(page 3. - Concepts continued)

John Tenten residences are not nursing homes. On the contrary, they do everything to keep people out of nursing homes. And their track record is extraordinary. Last year, at Lilac Plaza, with 220 residents, many of them well up in years, only five had to go to a nursing home during the entire year. That may well be a national record.

4. Active Social, Spiritual, Educational, Recreational and Vocational Programs "There is always something going on", say our people. A person can have as much or as little to do as they please. They can be with people if they want to, or enjoy the privacy of their own lovely apartment. The magic is in having the options! Loneliness - frequently the heaviest of all burdens for retired people - simply doesn't exist, or needen't exist. John Tenten residences have a magnificent array of planned and spontaneous activities. Each has a Craft Room...Woodworking Shop... Library...Lounge...All-faiths Chapel...Beauty Salon...Exercise Room...Game Room...Commissary..Laundry...and a large farm & garden area. A Residents' Council makes decisions for programs and activities in a democratic, participatory manner.

(page 4.)

FINANCING

The financial structure behind John Tenten residences is perhaps the most innovative and effective in America today. It seems ideally suited to today's economy and the mindset of today's Seniors.

1. Modified Condominium Concept The residents who will live in the home, provide the money for its construction. Seventy percent of retired people own their own homes. The sale of their home provides the money for purchasing an apartment unit. With home prices as inflated as they currently are, and with our residence prices so low, relatively, a person usually realizes additional equity from their home sale, that becomes available to invest or enjoy. Financing can be arranged to bridge over any length of time it might take a house to sell.

Pre-selling of units provides a base for borrowing money to assure completion of the project. No building is begun until financing adequate to complete the project, is obtained. Until such time, pre-sale monies are placed in escrow, providing total security for unit investors. The John Tenten Group assumes responsibility for obtaining all financing if the sponsoring organization wishes this service.

2. Refundable Purchase Price The residents purchase their apartments, and whenever they leave, for whatever reason, their money is refunded in full (less a 10% reserve). The refund may be given or willed to an heir, as the owner chooses. This is in contrast to traditional retirement homes where the money reverts to the organization. This Refundable concept is new and ideally suited to our modern times and thinking. It is simply a matter of building the refund into the proforma up front, with the refund made when the unit is resold.

In addition to the purchase price of a unit, the resident pays a moderate monthly fee that covers their meals, maintenance, and all other expenses except personal telephones. The fee is typically about $325 to 375 a month for a single person; $425 to $475 for a couple.

3. Nonprofit / Non Governmental Most organizations the John Tenten Group serves are nonprofit (church organizations, civic groups, etc.) enabling residence units to be offered for sale at just what they cost to build. Meals and maintenance, because they contain no profit motivation, can be provided in an uncompromised quality manner.

Where a community needs and wants a residence but has no one organization to undertake the work, the John Tenten Group may assist in developing a community organization that will qualify for nonprofit status. In some cases a coalition of different groups can be put together to form a sponsoring organization.

(page 5. - Financial continued)

All building undertaken by the John Tenten Group is self supporting , free enterprise, requiring no government funds or involvement.

Modifications can be made in the preceeding programs to suit local conditions and attitudes, but it is important that the main elements essential to quality retirement be preserved.

(page 6.)

SERVICES
OFFERED BY THE JOHN TENTEN GROUP

1. Market feasability research
2. Setup of sponsoring organization
3. Concept planning
4. Site selection, zoning, permits, other legal requirements
5. Architectural design & engineering
6. Construction supervision
7. Financing
8. Marketing & Sales
9. Staffing assistance
10. Management & operations (manual / training)
11. Quality-of-life programming (manual / training)
12. On-going consultation and quality control

PROFESSIONAL STAFF OF THE JOHN TENTEN GROUP

John Haugan President of The John Tenten Group.
Pastor, builder, author, administrator. Nationally recognized authority on aging. Delegate to the White House Conference on Aging. Administrator of the 175-unit Lilac Plaza and 96-unit Holman Gardens, Spokane, Washington. John has a special gift of compassion and concern for the elderly, and has been a prime mover in developing many new advances, including legislative changes, enriching the lives of retirees.

John Molander Architect & Design Engineer.
One of the foremost designers or retirement residences in the nation. Principal in the firm of The Molander Associates, Spokane, Washington. John has designed many of the outstanding landmarks in the Northwest, including the Cheney Cowles Museum, KHQ TV & Radio Studios, over a dozen buildings on the Whitworth and Washington State University campuses, and many churches, schools and commercial buildings throughout the region. His firm now devotes its services almost exclusively to retirement homes , having built eight of major importance.

Geraldine Brown Realtor, Sales Counselor, Public Relations specialist. Geraldine brings over 20 years of sales and public relations experience to the John Tenten Group. She is responsible for selling and setting up sales organizations in the communities in which the Group works. She works with rare sensativity in dealing with elderly persons. Geraldine is a long time director of the Spokane Baptist Association Homes, Inc., owners of Lilac Plaza and Holman Gardens.

Richard Maginot Marketing & Sales.

A marketing professional for 30 years; in senior management positions in three billion-dollar corporations: Vice President of Marketing for all Bon Marche Stores. Vice President of Marketing for the May Company, Colorado Division. Member of Management Board of the Dayton Company. Honored nationally in Who's Who. Recipient of the Socrates Award for the best advertising in America in his field. Dick now devotes his full time to marketing and sales in the John Tenten Group.

Other Professional Associates

Financial: Roger Fruci & Associates PS, Certified Public Accountants
Thomas Brown, Financial Consultant
Helen Berglund, Financial Consultant
Legal: Clausen & Brown, Attorneys

(page 8.)

BUILDING PROJECTS

Lilac Plaza, Spokane — 175 units, 220 residents, $5,000,000

John Molander designed and built this magnificent high-rise apartment complex in 1972. John Haugan has been its Administrator since its inception. It was here that "Full-Program" retirement was developed as a concept, and then a reality by John Haugan.

Holman Gardens, Spokane — 96 units, 120 residents, $5,000,000

Designed, built, marketed, sold, and administered by the John Tenten Group for Spokane Baptist Association Homes. A deluxe two-level condominium-style residence , first in the nation with a fully integrated wholistic health facility containing an indoor walking-jogging track, indoor swimming pool, and hot tub/spa.

Hill-Ray Plaza, Colfax, WA — 42 units, 1st phase; 42 additional units, 2nd phase; $4,100,000

The first "Full-Program" residence to be built in the great Palouse Country. Initiated by a group of concerned local citizens who formed a nonprofit community organization and engaged the John Tenten Group to do the complete package. Construction announced for October, 1983.

Lewiston-Clarkston Retirement Center — 120 units, 150 residents, $5,500,000

Land has been optioned and a community organization formed to spearhead this first-of-its kind retirement residence to be shared by the Idaho and Washington cities of Lewiston and Clarkston. Startup is planned for early 1984.

(page 9.)

Other Retirement Residences
built by The Molander Associates

Locations in Washington State:

Deer Park (2)	Harrington
Lacrosse	Chewelah
Creston	(Plus Lilac Plaza and Holman Gardens listed previously)

(page 10.)

CRITERIA USED FOR EVALUATING
REQUESTS FOR HELP

The John Tenten Group evaluates requests for assistance, based on the following criteria:

NEED — The number of retired persons living in the area, needing housing. The number and quality of retirement facilities currently in the area.

SUPPORT — The makeup and strength of the groups and individuals in the community who will constitute the support group(s) for the project.

The Group welcomes inquiries, and would be pleased to host individuals and groups wishing to come to Spokane to visit Lilac Plaza and/or Holman Gardens and see "Full-Program" retirement in action.

CONTACT: The John Tenten Group
N. 7007 Wiscomb Street
Spokane, WA 99208

(509) 489-7612 or
928-7020

(page 11.)

MARKETING FACTS

OF SPECIAL RELEVANCE TO

SENIORS

Seniors age 65 and over represent the fastest growing demographic segment of American society. This year they passed the Teenage Group as numerically the largest age group in the United States.

The number of Seniors has doubled in the past 30 years (from 12.5 million in 1950 to 25 million in 1980 - a 100% increase).

The number is expected to double again in the next 30 years (from 25 million to over 50 million)

In 30 years from now, one out of every four Americans will be 65 or older.

The need for quality housing for Seniors is presently considered "Acute" in many areas of the U.S.

Retirement homes being built now are filling a great need, and seemed destined to be in high demand both now and in the foreseeable future.

ITEM 7

5719 S. Morgan Place
Seattle, Washington 98118
July 19, 1984

The Honorable Daniel J. Evans
Special Committee on Aging
Washington D.C. 20510

Dear Senator Evans:

I want to thank you for inviting me to attend the hearing of the Senate Special Committee on Aging on July 10th and making it possible for me to add some remarks at the close of the scheduled testimony. As I mentioned, I am currently Vice-chairperson of the Seattle-King County Advisory Council on Aging and Chairperson of the Council's Long Term Care sub committee. Having worked with the elderly and their families for over 15 years at the University Hospital and the Family Medical Center at U.H., in particular, I became very familiar with the needs of the elderly.

I want to reiterate a few points made at the July 10th hearing: many times social, emotional and environmental factors have an impact on illness and result in reduced functioning of the elderly. Therefore, it is highly important to provide social services including case management to the elderly and their families. This,not only, will help keep the elderly from costly institutionalization, but will add to the quality of their lives.

Because of the complexity of social services: large numbers, diversity, eligibility factors, locations, waiting lists, access and continuous changes (services--droppped services because of reduced funding and new services, locations, etc. This requires a skilled person, who is working constantly with the agencies and the various services in order to seek out the most appropriate and available service and to bridge the needy person and the service. Follow-up and a review schedule is necessary: are the needed services being provided? Are there changes which would reduce or increase the need for service or change of services? Hence, case management--Senior Information and Assistance and Outreach are vital. Funding must be adequate for these services.

I reiterate from my testimony: all health services to persons with long-term, chronic conditions should be pooled. States should be given prospective payments, based on good estimates of the frail population at risk for institutional placement. This allocation should be based on adequate estimates, reflecting the accurate growth of the aged population annually and include a reasonable, planned inflation factor in line with the economy as a whole....tax credits for families carrying for the frail elderly at risk for institutionalization would make it possible for more elderly to be cared for at home.

As I mentioned at the hearing, the Long Term Care sub-committee of the Seattle-King County Advisory Council on Aging will submit written testimony following the next meeting, August 7th. If I or the LTC committee can be of to you, please let me know.

Sincerely,

Reva

Reva K. Twersky

APPENDIX 2

LETTERS AND STATEMENTS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER AND ENCLOSURE FROM EDGAR F. BORGATTA, PH. D., DIRECTOR, PACIFIC NORTHWEST LONG-TERM CARE CENTER, UNIVERSITY OF WASHINGTON, SEATTLE, WA, TO SENATOR DANIEL J. EVANS, DATED AUGUST 14, 1984

DEAR SENATOR EVANS: I am pleased to have the opportunity to submit the attached written testimony for the Senate Special Committee on Aging, Seattle field hearing.

I appreciate the assistance your legislative assistant, Lisa Marchese, has provided to the Long-Term Care Center's Liaison Specialist Liz Roberts in scheduling mutually convenient deadlines for submittal of the Center's testimony. Ms. Roberts represented the Center at the July hearing and will continue to be the primary contact person with your staff.

Please let me know if you or your staff would like additional information on the Center's projects. We look forward to a continuing working relationship.

Sincerely,

EDGAR F. BORGATTA, Ph. D.

Enclosure.

STATEMENT OF DR. EDGAR F. BORGATTA

I am pleased to have this opportunity to submit testimony on behalf of the Pacific Northwest Long-Term Care Center to the Senate Special Committee on Aging.

As you know, the Pacific Northwest Long-Term Care Center, located at the University of Washington in Seattle, is one of the 11 long-term care gerontology centers funded by the Administration on Aging under the auspices of the Older Americans Act. The Center, which was established in 1980, engages in research and demonstration projects, works with community agencies to develop service models, develops and offers training programs and conferences, and provides technical assistance and information to the aging network in region X: Alaska, Idaho, Oregon, and Washington. The Center is formally affiliated with the six health professional schools in the Health Sciences Center of the University of Washington and is advised in its activities by a regional steering committee composed of the four State directors on aging in region X and the region X program director of the Administration on Aging.

The growing population of older persons, coupled with the growing cost of long-term care, presents a major challenge to government, business, philanthropy, and education, particularly in the Pacific Northwest. Three of the twelve States which have had elderly population increases of at least 10 percent since 1980 are in the Pacific Northwest: Alaska, with an increase of 23.6 percent; Idaho, with an increase of 11.6 percent; and Washington, with an increase of 10.8 percent.

Operating on the basic premise that there is no single answer for the needs of the chronically ill elderly and there is no single answer for improving the long-term care service delivery system, the Center in its research, training, education, technical assistance and information dissemination roles strives to explore multiple alternatives and options along the continuum of care. Therefore we are working collaboratively on projects and programs in institutional and community based care. We are involved in rural and urban settings, in exploring models in the academic setting and in the field and in providing training and education for

the present and the future practitioner. We are in fact implementing the focus of this hearing: partnerships.

For the information of the committee, and other interested persons, I would like to provide brief descriptions of the Center's projects which have national implications. I would of course be happy to provide more detailed information upon request.

ALTCARE

Policymakers at all levels of government are faced with decreased public resources and an increased demand for long-term care services. In their efforts to meet this demand and to keep costs from further accelerating, they are being forced to consider changes in the availability of services, in reimbursement rates and eligibility criteria. To date, however, policymakers have not been able to forecast the likely ramifications of their policy changes.

Altcare is a computer based planning program developed by Center staff which we hope can be used by policymakers at the local, State, and national levels to study policy options for long-term care services and to analyze the impact on a broad spectrum of services.

Two major projects in the coming year will be extensions of the Altcare model. In the State of Alaska, the original intent was to adapt Altcare for use in planning long-term care services in Alaska. However, additional opportunities arose to gather vital information about the total population of older Alaskans and to develop tracking systems that would ultimately provide a wealth of information needed for accurate planning and reporting.

This project has State, regional, and national implications. By providing the State with the first set of reliable data on the characteristics of its older population and patterns of health and social service use, the project will provide the foundation for making critical policy decisions concerning long-term care services. In addition, by providing a tracking system, the project will enable continued collection of data in a form that can be used for planning as well as providing of status reports in a cost efficient manner. The completed tracking system can provide a prototype for State units on aging and area agencies on aging throughout the Nation.

The other project which will build on Altcare is in Island County, WA, where the model will be utilized as a planning tool for projecting nursing home bed needs. In cooperation with the Puget Sound Health Systems agency and the area agency on aging for that county, the Center will obtain data to implement Altcare and will apply it to obtaining information necessary to address critical long-term care policy decisions at the local level. Like the Alaska project, Island County has local, regional, and national implications. Of special importance is the ability to account for the supply and demand of community based services when addressing policies governing the supply of institutional services.

FAMILY SUPPORT PROJECT

The Family Support Project is a 5-year federally funded research and demonstration project of the Center. The purpose of the project is to determine what types of services best help families who are caring for, or regularly assisting their impaired elderly members. Both the Health Care Financing Administration and the Administration on Aging have provided funding to the project, which is based in King County, WA.

Services provided by the program include family education seminars covering a wide range of information useful to persons who are assisting an elderly relative; family coordination services providing a social worker to visit and consult with families and elderly clients; caregiver support groups for families who wish to share their experiences, learn coping tactics and meet new friends through these groups; and respite services available to families in their homes, in a nursing home, or in an adult day care setting. Over 1,000 families are expected to participate in the experience before its completion in 1986.

CASE MANAGEMENT

Health and social service programs for the elderly are often fragmented. Programs differ, eligibility for program participation varies greatly and numerous organizations and agencies provide a variety of different services. This can be a frustrating and time consuming maze for frail elders and their families as they attempt to find and obtain needed services. To address these problems, case

management has increasingly been a key recommendation for improving the long-term care delivery system.

However, case management programs across the country differ in several important dimensions. We have begun work on a project which will identify, retrieve, analyze, and classify approaches to case management that have been developed by organizations involved in the delivery of long-term care services. Particular attention will be paid to developing an understanding of what kinds of case management are implemented in different settings. We will publish a volume from this activity that it will be disseminated nationally to the aging network.

VETERANS ADMINISTRATION/ADMINISTRATION ON AGING COLLABORATION

In 1976, there were 2.3 million veterans 65 and older; today, there are 4 million. By 1990, the number will grow to 7.2 million and by the year 2000, to 9 million. As they age, many veterans will need a mix of acute and long-term health care that the VA medical system is not equipped to provide.

Since January 1984, the Pacific Northwest Long-Term Care Center has been a participant in a joint working group of the Veteran's Administration and the Administration on Aging. This group has been exploring potential collaborative projects. These deliberations could stimulate the development of several demonstration efforts between the two agencies that would enhance each agency's capacity to provide comprehensive services to their elderly clients. At the regional level, we have also been exploring closer coordination and cooperation between these two systems.

ALZHEIMER'S DISEASE

In light of the growing numbers of individuals and their families who will suffer the consequences of Alzheimer's disease, the Center has been and will continue to be involved in a number of projects related to this debilitating disease. We have been participants, with other departments at the University of Washington, in a number of research projects including the epidemiology of Alzheimer's and adaptation among the elderly with Alzheimer's.

Additionally the Center, in response to the Administration on Aging's initiative on the development of caregiver support groups, will sponsor a day-long conference in September for Washington State service providers and other interested persons, titled, "Alzheimer's Disease: Supporting the Caregiver." Building from the conference, we also are planning the development of a public information package to be utilized by area agencies on aging and other components of the aging network to provide basic information on the nature of the disease, its impact on families, the value of caregiver support groups, and related issues.

I have provided brief summaries of some of the service models and research projects which we are working on. Additionally, we are, on an ongoing basis, actively involved in educating new practitioners, providing ongoing training to professionals in the field, providing technical assistance to community agencies, and disseminating information to the professional and the public.

We feel our projects will be of value only if they are known by legislators, by researchers, by workers in the field. Long-term care gerontology centers have a unique opportunity to influence the design and the cost of a major service delivery system: long-term care to the chronically ill elderly.

At the Pacific Northwest Long-Term Care Center, we have made a concerted effort to work collaboratively with local, State, and Federal levels of government, with private community agencies, and with other educational institutions. We are pleased that Senator Evans is representing the Northwest on the Senate Special Committee on Aging. We look forward to working with Senator Evans and other members of the committee in our common pursuit of improving the effectiveness and the efficiency of our long-term care services.

ITEM 2. LETTER AND ENCLOSURE FROM FRANK BAKER, VICE PRESIDENT, WASHINGTON STATE HOSPITAL ASSOCIATION, SEATTLE, WA, TO SENATOR DANIEL J. EVANS, DATED JULY 18, 1984

DEAR SENATOR EVANS: I was delighted to have the opportunity to visit with you during your time in Seattle last week, and to again share ideas about the health care delivery in Washington. We are working on the comparative data on

medicare costs in Washington and the national average, and will forward it to you as soon as it is completed.

We also appreciate the opportunity to present our enclosed testimony to the Senate Special Committee on Aging. We offer our suggestions in the context of the unique and cooperative efforts that characterize the health care environment in Washington. As we have discussed, it is this environment of collaborative effort that contributes so much to the innovative and effective solutions developed here.

We look forward to hearing the conclusions reached by your committee and for continuing opportunities to work with you on these and other health issues.

Sincerely,

FRANK BAKER,
Vice President.

Enclosure.

STATEMENT OF THE WASHINGTON STATE HOSPITAL ASSOCIATION

The Washington State Hospital Association is pleased to offer testimony on behalf of its 119 member hospitals to the Senate Special Committee on Aging. We are sympathetic to and supportive of desires to foster individual independence and appropriate long-term care service utilization for the elderly of the State. We also recognize the potential social advantages associated with the development of noninstitutionally based long-term care programs for the future. We do feel strongly, however, that a consideration of the implications of such decisions on the hospitals in the State should be part of the policy/design process.

Acute-care hospitals have not, for the most part, been included in the debate over the future of long-term care. This exclusion may seem reasonable to policymakers, who already face an exceedingly complex set of service providers and funding mechanisms. It is certainly true that the proportion of long-term care provided at present by acute-care hospitals is relatively small. The fact remains, however, that in 1983 12 of Washington's community hospitals operated long-term care units, providing 125,000 days of care. On an "average" day in 1983, then, some 350 residents of the State received care in a unit that was designated as long-term, yet was operated by an acute-care facility. At present, in three counties (Ferry, Garfield, and Lincoln), the only formalized long-term care services available, are operated by community hospitals. In addition to these long-term care units, some 16 of the State's community hospitals participate in the "swing bed" program, which allows small rural facilities to utilize a specified number of beds on either an acute or a long-term care basis, dependent upon the needs of a particular patient.

In summary, then, Washington's community hospitals at present play a small, but in some areas, vital role in meeting the long-term care needs of the State's elderly population.

As we look to the future, however, it appears certain that demands on the resources of many of the State's community hospitals will come more and more from the long-term care continuum. The growth in the number of elderly, if coupled with the continued development of State and Federal long-term care policies which discourage the expansion of nursing homes, can be expected to create an environment in which community hospitals will provide an ever-increasing portion of the skilled long-term care needs in the State, especially in rural communities.

In an effort to develop effective and efficient models of care in view of these trends, we would add our voice to the chorus in calling for improved coordination of the mix of providers and payers for long-term care services. A single entry system of care which provides appropriate, sensitive, and efficient treatment will be difficult to design and maintain. It is much more likely, we believe, that such a system can be developed which is responsive to the particular resources, needs, and desires of a given community through local and State initiatives rather than through broad systemwide directives. In many communities and particularly in rural areas, the tax-supported community hospital is the focal point for health care, and, we believe, the most logical coordinator for the continuum of services which will be required in the future.

With this in mind, we would propose the following suggestions for legislation which, from our perspective, would encourage effective and efficient care.

A vertically integrated system of care is essential. This involves the capability, on the provider side, to offer a comprehensive set of services to the community it serves. The Washington State Hospital Association would propose the following

specific adjustments which would allow for the development of such services by community hospitals:

(a) Eliminate certificate of need requirements for "swing bed" participation in rural areas, in cases where hospitals add no additional beds. The cost of preparing for certificate of need review often outweighs the marginal benefits of participation, with the result that rural hospitals are unnecessarily underutilized and community long-term care needs are unmet.

(b) Prohibit certificate of need requirements for hospital-based home health programs. This would be in line with the report of the House Committee on Interstate and Foreign Commerce (H. Rep. No. 96–190, May 15, 1979.), which clearly stated the committee's position that supply of these services would respond to market forces if left unregulated. Similar consideration should be given to programs for respite care and day care.

(c) Relax statutory constraints on the size and location of hospitals which may participate in the "swing bed" program. At present the program is limited to hospitals with less than 50 beds in rural areas; small (100 to 125 bed) urban and suburban hospitals are faced with difficulties gaining access to medicare-certified nursing home beds on one hand, and occasional underutilization on the other. A moderate expansion of swing bed utilization would contribute to effective resolution of both problems.

(d) Continued discussion and demonstration projects regarding case-management for the elderly seems both timely and reasonable. In urban areas, in particular, this model for service coordination deserves continued attention.

In summary, we are convinced that the development of efficient and effective long-term care systems can be accelerated by the introduction of carefully conceived and designed incentives. However, the growing number of elderly will increase the demand for these services, and the increasing lifespan of the elderly population will compound the severity of their health problems. Even significant advances in efficiency are unlikely to lower the total cost of the care system given these realities; the best that can be hoped for is moderation in the rate of cost increases.

This growth and aging of Washington's population presents sensitive and difficult issues to both policymakers in government and community health care providers. There is no question that meeting the dramatic health care needs which are now commonplace in forecasts for upcoming decades will require dynamic leadership and creative adaptation in our health care facilities. Washington's system of hospitals is, by all common measures, one of the most efficient provider of acute care services in the Nation. We stand ready to participate in a sensitive partnership of citizens, public agencies, and private sector groups, and look forward to developing innovative programs of care that will encourage the independence and dignity of our elderly, support the invaluable aid of their families and friends, and promote high quality, fiscally responsible systems of care.

ITEM 3. STATEMENT OF SUE LOPER-POWERS, SEATTLE, WA, PRESIDENT, WASHINGTON STATE NURSES ASSOCIATION

Senator Evans and members of the Senate Special Committee on Aging, my name is Sue Loper-Powers. I am speaking as the president of the Washington State Nurses Ascociation. We appreciate this opportunity to present testimony for the hearing, "Long-Term Needs of the Elderly: A Federal-State-Private Partnership."

As the profession providing the largest portion of health care services to the senior population, registered nurses have a key to play in the creation of a more responsive health care system for the elderly. The prediction of a burgeoning elderly population in need of services in combination with the rising cost of health care and a frightening national deficit make a national long-term plan for elder health care vital and the time frame all too short. Any plan developed must maximize the independence of the elderly individual, sustain and support the family and friend caregivers, and provide an adequate supply of appropriate level services. As mentioned in earlier testimony common national goals and objectives, stable funding sources, common eligibility requirements consistently applied and sufficient flexibility of programs to encourage creativity are essential.

The plight of elderly citizens and their families has been clearly and repeatedly outlined in previous testimony, therefore, we will not repeat those articulate arguments. We will, however, note that emphasis on a multifaceted system is crucial. This requires the building of a health care system not merely a medical system. Medical care, the diagnosis and treatment of illness, is only one segment of an adequate health care system for the elderly. Systems for the provision of health maintenance and restoration, preventive and social services must be included in a comprehensive system.

Nursing is a health care discipline that is responsible for the provision and planning of care, and the provision of care is the issue. Nurses assist families and individuals to cope with illness and obtain their highest level of functioning. Nurses teach coping skills. We would like to submit the following suggestions for utilizing an underutilized resource, registered nurses. To plan a responsive health care system for the elderly, we recommend:

(1) The establishment of community nursing centers (S. 410, Inouye and Packwood). See attachment. We would suggest contacting ANA, 2420 Pershing Road, Kansas City, MO, 64108, (816) 474-5720 for further information.

(2) Financial support of training programs for gerontological nurse practitioners and the use of these highly skilled, cost-effective health care providers in nursing homes, clinics, home-health care, etc. Currently, a 3-year research project is being conducted by the Rand Corporation and Mountain States Health Corporation to study the cost and quality effectiveness of GNP's in nursing homes. Contact Robert Kane, M.D., the Rand Corporation, 1700 Main St., Santa Monica, CA 90406, phone (213) 393-0411 or John R. Kress, senior staff associate, Mountain States Health Corporation, P.O. Box 6756, Boise, ID 83707, phone (208) 342-4666 for further information.

(3) Changes in medicare regulations to enable the direct third-party reimbursement of nurse practitioners for services provided to the elderly. Currently, any medicare reimbursement of nursing services is tied to physician referral. As much of the care required by the elderly is of a chronic nature, the appropriateness of this is questionable. We believe unnecessary restrictions on reimbursement for nursing services, particularly reimbursement of nurse practitioners by medicare, should be eliminated. A recent report of the House Select Committee on Aging encourages removal of obstacles to the use of nurse practitioners to improve access to quality health care.

(4) Any health care system for the elderly be designed with adequate consultation and participation of registered nurses. We suggest contacting the American Nurses Association which has access to the foremost gerontological nurse experts in the Nation.

Nurses have always been providers of care for underserved populations and have worked for years to improve health care to the elderly. Well-educated, registered nurses are presently dispersed at all levels of healthcare and are providing care to the elderly. Their full participation in planning and adequate utilization in care delivery can only strengthen cost-effective service to this well-deserving population.

ITEM 4. LETTER FROM ELAINE G. McINTOSH, SEATTLE, WA, PRESIDENT, BOARD OF DIRECTORS, WASHINGTON STATE HOSPICE ORGANIZATION, TO SENATOR DANIEL J. EVANS, DATED JUNE 22, 1984

DEAR SENATOR EVANS: In earlier communications to you, the Washington State Hospice Organization has expressed concern regarding the medicare hospice benefit. This letter gives greater detail about our concerns which are classified in three areas; administrative, financial and ethical. I will attempt to capture the specifics of our concern below.

ADMINISTRATIVE

1. The law requires that the hospice provide and be responsible for essentially all aspects of the patient's care; care received at home, in an inpatient setting, all pharmaceuticals and supplies, all outpatient treatments, all medical equipment used. This means that a hospice must operate a far wider array of services than are currently the usual practice in hospice. There are multiple problems with this.

The vast majority of hospices are small, community based organizations which are not prepared to assume the administrative burdens and costs associated with

such an operation. Though many small hospices are being acquired by large organizations, the burdens still appear excessive, especially in view of the uncertain number of patients who are likely to make use of this program.

2. The mode of operation required by the law is in direct conflict with the practice patterns which currently exist in most Washington communities. Few hospices, especially on the west coast, are so centralized as to be able to manage the medicare program. Most hospices work with a variety of different organizations and individuals to achieve their ends. For example, Hospice of Seattle, a home care hospice, serves patients who would use, if necessary, any one of 17 area hospitals. The administrative burdens of managing the care for a handful of patients from outside the hospital in 17 different sites, are staggering.

The law also requires that the hospice be "professionally, managerially responsible" for all aspects of care, including inpatient care. This means that the hospital must allow the hospice home care provider to dictate what goes on during the time the patient is hospitalized. Few hospitals, let alone the patients' personal physicians who historically have been the source of "orders" for patient care, are willing to give up control of patient care. The legal ramifications of such an arrangement are unknown and for this and other reasons the American Hospital Association has recommended to its members that they not participate.

3. The 80/20 rule. The statute states that no more than 20 percent of all patient days can be institutional days. All hospice providers recognize and agree that the goal is to keep the patient home if at all possible. However, no program can predict what the absolute number of patient days, in home and in institution, will be. Further, this is not a per patient ceiling on the number of days, it is a per agency ceiling. So literally, every day of the year, the hospice must compute how many days of inpatient care they have available to "spend" on their current patients. This is a management and ethical nightmare. What does the program do with a patient who needs to be in the hospital and they have no inpatient days left? The program must make a choice between taking the financial loss of paying for the hospital care or deny the patient needed care.

4. Patient election of the benefit. In order to be on the medicare hospice benefit, the patient must "elect" this program and waive their rights to their traditional medicare coverage. This will discourage many people from using the coverage. It requires the person to psychologically acknowledge that they will soon die. This is simply not compatible with most peoples' attitudes at this time. Patients still hope, they still want access to treatment if something becomes available, they still need to be allowed to cope with their illness in their own way, including avoidance of the subject altogether. Though the patient can revoke the benefit, that really does not solve the problem. The stress of such decisions in and out of this program is a burden these people don't need.

Financial

Hospice care has never been delivered in the manner described in the hospice law. Therefore the data which would tell us the cost of this care is simply not available. The Health Care Financing Administration (HCFA) does not know it, the HCFA hospice demonstration project does not provide it, and the hospices don't know it. Therefore we have no basis upon which to evaluate the adequacy of the areas. Yet the hospice must be financially responsible for everything the patient needs. We cannot calculate the actual potential financial liability. We do know that many hospitals in this area will not contract with the hospices for this care because the general inpatient day rate of $271 is too low.

Ethical

Ethical concerns exist in two primary areas. First, day to day management of patient care will be ethically challenging because of the 80/20 split, financial constraints, and informed consent requirements. However there are other ethical concerns that are far reaching for our society. The public policy implications in the medicare hospice law is that if you are dying, you are not worth expenditure of as much money as others and you may not have access to certain things. The hospice movement has stood for something quite different. That is that the dying person does still matter, and that society does still care and that the dying will not be abandoned.

Though all health care providers are acutely aware of the scarce resource problem, we do not feel that such a policy as this should be entered into accidentally—as occurred with the passage of this law.

A few of the WSHO's members are planning to try to make this program work. They however concur that this program is risky in many ways and realize that they may not succeed.

Medicare beneficiaries need access to hospice care, hospices need medicare reimbursement to survive. Unfortunately, this program is unlikely to move us much closer to either of those ends.

I am grateful for your interest and patience and hope this has helped you to understand our concerns. I look forward to further communication with you on this important subject.

Thank you.

Very truly yours,

ELAINE G. MCINTOSH.

ITEM 5. STATEMENT OF RICHARD F. GORMAN, SEATTLE, WA

I am a retired senior citizen, 68 years of age. For 25 years I served on the staff of the Washington State Medical Association. During that time I answered as best I could many questions of the elderly and their relatives and friends on many of the subjects being considered at today's hearing. These were questions about the personal concerns which lie behind the financial and delivery problems being discussed here.

One of the benefits of a career in health services is that when you retire, your similarly elderly relatives and friends contact you for advice and assistance on their medical and health problems, including those of long-term care. As a result I have found myself assisting several with chronic disease problems and terminal illnesses. These experiences have provided me with a new kind of look at the health services financing and delivery systems I worked with so closely for 25 years before retiring. Each week, now, I find more things to speak out about regarding all that's being talked about and considered relative to the entire health and medical care situation.

Specific to this hearing today, my experiences lead me to strongly advocate finding ways for us elderly to be interdependent persons with something to give each other in our personal human and physical environments to enhance the quality of our health care and our lives.

I understand the General Accounting Office and the Department of Health and Human Services have studies showing that 60 to 80 percent of long-term care is provided informally by spouses, other relatives and friends. Nursing home use rates for unmarried (widowed and single) are considerably higher than for the married elderly.

As many as 40 percent of nursing home patients could return home if appropriate support services were available. This means visiting nurse services, hospice and home health services, etc. When these are provided there is little evidence of significant reduction in total long-term expenditures.

I ask: Are there ways the elderly themselves can do more to help each other to keep a high percentage of informally provided care? Can we reduce nursing home use rates of the unmarried? Can we return nursing home patients to their homes? I suggest the elderly themselves can do something to provide a start on affirmative answers.

I suggest serious consideration be given to ways and means by which the Federal Government can encourage the elderly to help each other. I have real misgivings about such an effort becoming super organized. I feel this kind of interdependent activity needs to be fostered and encouraged by community groups: organizations of seniors, churches, unions, and others.

A very practical thing the Federal Government could consider is to provide that senior citizens who give this kind of help and service would be exempted in appropriate degree from the new taxes on their monthly Social Security checks.

Much more needs to be done to translate this suggestion into our daily life. But this may be an idea to start on in tapping the energies and participation of retired persons in solving some of the problems connected with aging and long-term care.

I appreciate having the opportunity to make my views known and am hopeful the Senate Special Committee on Aging will be able to give them further consideration.

ITEM 6. EXCERPT FROM LETTER FROM CARL R. JOHNSON, EXECUTIVE DIRECTOR, COLUMBIA CLUB OF SEATTLE, WA, TO SENATOR DANIEL J. EVANS, DATED JULY 20, 1984

DEAR SENATOR EVANS: My comments on the "alternative model" section are these:

(1) Three of them would hardly be called models—they have existed long enough to be called institutions.

(2) "Four models"—two of them, HMO's—hardly speak to the actual creativity we have here in Washington State.

(3) The Lilac Home story was a model although it is limited to the small percentage of the senior adult population who live in retirement homes.

I will see that your office will get more information about Columbia Club, material which the other Congressmen have received through the years.

Columbia Club should have been an alternative model. A few of its first are: First research nutrition site on the west coast (one of ten congregate sites in 1968), first nutrition site to have health screening and foot care service, first to have hearing testing (and providing hearing aids—1973), first RSVP site and the largest today in King County. I don't particularly like to have Columbia Club classified as a senior center because of the connotation. Rather, it is more a regional center whose "members" come from every area of King County plus Pierce and Snohomish Counties. The main emphasis, in this order, is: Health, exercise, education, and participation. Excellent linkages have been made with several agencies to provide the needed services. Those we provide are funded from donations, contributions and grants.

In the area of health: Hearing and testing, health screening, foot care, diet assistance, hot meal at noon, health screening with a new topic each month and the requirement that to get free screening one must attend the introductory lecture. Mental Health support groups. Counseling for groups and individuals.

In the area of exercise: Tai Chi, Yoga, senior exercise, aquatic exercise in shallow and deep water, senior swim, dancing.

In the area of education: Seattle Central Community College in a weekly lesson plan, current event, Spanish language, Mandarin language, conventional English, Braille, Tuesday seminars.

In the area of participation: In 1983, 171 volunteers 60 and over contributed 34,430 hours—at minimum scale—an in-kind contribution of over $100,000. Duties extend from kitchen to teaching to administrative assistance.

The services we provide are at no cost to the taxpayer. In addition to the local contributions, we are able to encourage doctors and other professionals to volunteer their time. Beside being cost-effective, it helps the senior adult with scarce dollars. Health screening is $2.50 (free if patient cannot pay). Compare that with charges of $10, $20, or more for similar services by a doctor.

We are serving a population 91 percent of whom are 80 percent of the median income and below, and 36 percent are at 30 percent of the median and below. Twenty percent of the population are minorities with Chinese being the largest group, followed by Filipino, Chicano, black, and Native Americans.

The Glaser Foundation over many years has believed in the direction we are going and has funded a major share of the services. To its board, we will be always grateful.

In 1974, the meals came under the King County Nutrition Program. Long before that, we had shown that the meal was the "carrot" which brought people out.

Professionals were hired (or volunteered) for blocks of time. Service agencies were either paid by Columbia Club or volunteered their services. Prevention and/or health maintenance have been our basic story since 1972. All of these have made a cost-effective program serving an average of 170 persons a day.

On top of that, there is a separate organization known as the Downtown Senior Columbians for those who attend, made up entirely of senior adults and run by them, separately incorporated. They are politically involved with many of the activists being members. The Downtown Senior Columbians also have made contributions to Columbia Club.

The model that Columbia Club projects is for every one. I have written to President Reagan that the model could work as well with welfare recipients.

I believe a model that needs more publicity and research is the involvement of persons with less than doctoral degrees. Indeed there are many services that do not require a doctor or his high fees. I understand some hospitals have gone to employing only registered nurses who perform the duties that LPN's and aides did before. This, I believe, is going in the opposite direction.

The attachments to this letter are for your information—a letter I sent to the Advisory Council on Aging and a copy of our brochure.

In the long run, the direction of Columbia Club will prove to be the most cost-effective for everyone.

CARL R. JOHNSON.

ITEM 7. STATEMENT OF DOROTHY C. FLEMING, SEATTLE, WA

I was a concerned observer during this meeting. When medicare and medicaid function with the same rules and regulations; when local agencies coordinate their various activities the 15 percent of the elderly needing care will be helped with less trauma and expense as is now the case.

We do need a national perspective. Local community care is most important. We must not, I emphasize this point, lose a sense of proportion. There are those in other age brackets whose needs are also legitimate and must be met.

I am 76, a member of Group Health Cooperative of Puget Sound. Monthly dues are no longer reasonable. Time and effort are spent on programs duplicated elsewhere by local community based facilities, i.e., mental health services, nutrition counseling, alcohol and drug abuse programs, senior wellness program, etc.

By definition when does one become elderly—55, 62, 65, 67?

When is an income insufficient?

The bureaucracy rising from the long-term needs of the elderly is frightening.

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